Ministry of
Health Services

2004/05
Annual Service Plan Report

BRITISH
COLUMBIA

www.gov.bc.ca

National Library of Canada Cataloguing in Publication Data
British Columbia. Ministry of Health Services.
Annual Service Plan Report. — 2002/03 —

Annual.
Report year ends Mar. 31, 2004.
Continues: British Columbia. Ministry of Health Services. Performance plan.
ISSN 1703-4590.
ISSN 1708-1017 = Service plan — British Columbia. Ministry of Health Services.

1. British Columbia. Ministry of Health Services — Periodicals. 2. Medical policy — British Columbia — Periodicals. 3. Health services administration — British Columbia — Periodicals. I. Title. II. Title: Ministry of Health Services Annual Service Plan Report.

RA185.B7B74 353.6'09711'05 C2003-960149-8

For more information on the British Columbia
Ministry of Health Services
visit our Website at
http://www.gov.bc.ca/health/ *

Published by the Ministry of Health Services

* *Refer to note on page 3.*

106-00492/

Table of Contents

Message from the Ministers and Accountability Statements 5

Highlights of the Year 9

Ministry Operating Context 16

Ministry Role and Services 18

Summary Report on Performance 20

Summary Report on Resources 27

Appendix A: Report on Performance 28

Appendix B: Report on Resources 80

Appendix C: Core Business Areas 90

PLEASE NOTE: On June 16, 2005, the government ministries were re-organized to reflect the new cabinet responsibilities. Many of the website addresses and links in this printed report may have changed following the government re-organization.

- A list of the new ministries is available on the government website at http://www.gov.bc.ca — follow the links to Ministries and Organizations.
- An index of all 2004/05 Annual Service Plan Reports, with up-to-date website links, is available online at http://www.bcbudget.gov.bc.ca/annualreports/.

Message from the Minister and Accountability Statement

It is my privilege to present the 2004/05 Annual Service Plan Report for the Ministry of Health Services. This report describes the changes and improvements that have put our health system back on a sustainable track, and positioned us to deliver the best outcomes for the citizens of this province.

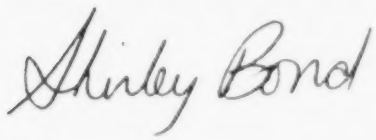
British Columbia's health system is in better shape today than 2001, the year we began fundamental reforms to improve patient care. This improvement can be measured in many ways. Organizationally, we restructured the administration of health care from 52 health authorities to six, a change that has led to more integrated planning and efficient management. We have increased health funding every year, improved accountability in the system and balanced the budgets for the ministry and the health authorities.

These structural changes have created a strong foundation. And through this foundation we have improved access to care, integration of services and providers, and outcomes for patients. British Columbia is at the forefront of innovation in Canadian health care. Our pharmaceutical pricing and chronic disease management approaches lead the country, while our cancer treatment network continues to contribute to British Columbians having the best cancer outcomes in Canada. We've invested across the continuum of care to deliver evidence-based, best practice health services that better meet people's needs. For example, we've modernized residential care to increase independence for seniors, and enhanced important services like BC NurseLine to ensure citizens have access to health information and advice when they need it.

In September 2004, British Columbia played a leading role in negotiating a new health deal for Canada. The First Ministers' Ten Year Agreement to Strengthen Health Care will increase federal funding for health services over the next decade. However, new funding alone cannot eliminate the challenges we face in making the health system sustainable over the long-term. We must continue to redesign the delivery of services to meet the growing demands for increasingly complex and expensive care.

The work of the past four years has left British Columbia well positioned to meet the challenges of sustainability. We will continue to work with the thousands of dedicated health professionals across the province to improve quality and increase capacity within the resources available. We will build on the foundation we have set, and make new investments across the continuum of health services to help people stay healthy, and provide them with top quality care when they do get sick.

This 2004/05 Ministry of Health Services Annual Service Plan Report compares the actual results to the expected results identified in the ministry's 2004/05 Service Plan. I am accountable for those results as reported.



Honourable Shirley Bond
Minister of Health Services

June 14, 2005

Message from the Minister of State and Accountability Statement

Government has given priority to mental health and addiction services over the past four years. Tremendous work has occurred across the province in the health authorities, between ministries and among stakeholders, consumer groups and families. British Columbia has taken significant steps to recognize the link between mental illness and addiction and to treat both as chronic health conditions requiring ongoing support.

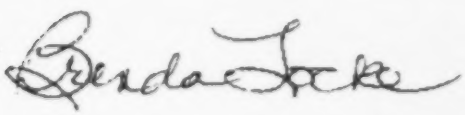
In 2004/05, we released *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction*. This work is guiding and supporting health authorities to ensure B.C. has a comprehensive, compassionate and effective response to problematic substance use and addictions. Flowing from this provincial framework and to address the growing awareness of methamphetamine use, the Province released *Crystal Meth and Other Amphetamines: An Integrated B.C. Strategy*, Canada's first provincial methamphetamine strategy. This effort, which includes the participation of six provincial ministries and all six health authorities, recognizes partnerships are necessary, across all levels of government and among community groups, professionals, individuals and their families, to ensure effective responses are in place to address crystal meth use and production.

In 2004/05, we also distributed Canada's first comprehensive clinical practice guidelines on depression to primary care physicians throughout B.C., and work continues on guidelines for anxiety disorders and substance use disorders. We also saw the launch of the Premier's Task Force on Homelessness, Mental Illness and Addictions, which, in partnership with seven municipal mayors and the federal government, is creating many new projects to address homelessness. And, as an ongoing priority, government has continued to focus on providing high quality mental health and addiction services for children and youth.

I am proud to have worked with partners throughout British Columbia on developing a modern, comprehensive and integrated continuum of mental health and addiction services that meets our citizens' needs.

I am the Minister of State for Mental Health and Addiction Services and, under the *Balanced Budget and Ministerial Accountability Act*, I am accountable for the following results for 2004/05:

Expected results	Results Achieved
Minister of State for Mental Health and Addiction Services	
• Develop revised guidelines with regard to the *Mental Health Act*, intended to facilitate a more effective system of mental health services and ensure the rights of persons with mental disorders are respected and access to care is provided and present the guidelines to the Government Caucus Committee on Health.	YES
• Develop a guide for general practitioners, families and individuals, intended to improve the education, prevention, self-management and treatment of depression, anxiety disorders and substance use disorders and present it to the Government Caucus Committee on Health.	YES
• In consultation with the Attorney General and Minister Responsible for Treaty Negotiations and the Minister of Public Safety and Solicitor General, develop a report with recommendations intended to improve integration, planning, services and supports for persons with mental and substance use disorders involved in the justice system and present it to the Government Caucus Committee on Health.	YES



Honourable Brenda Locke
Minister of State for Mental Health
and Addiction Services

June 10, 2005

Highlights of the Year

Introduction

A tremendous amount of transformation has occurred in the health system over the past four years. Significant reforms were begun in 2001, and through the dedication and hard work of health workers across the province those reforms have created a more streamlined and better-managed health system that is better able to respond to growing and changing public and patient needs. All along, the goal of these efforts has been to build a health system that delivers quality services for British Columbians and is sustainable into the future.

Though government has increased health funding every year, we also recognized that money alone would not make the health system more responsive to people's needs or sustainable over the longer term. It was also important that the health system be able to adapt and modernize to meet the changing demands of the public. In fact, a series of provincial and national studies have consistently cautioned against continuing to add resources without effecting significant change in the management and delivery of health services.

Accordingly, government undertook significant reforms to redesign the health system in British Columbia. As part of a commitment to better planning and management, government reshaped the health system and increased accountability. Key advances in improved planning, management and accountability include:

- Reduced the number of health authorities from 52 to six, resulting in a simpler, more accountable governance model for health service delivery.
- Introduced three-year service plans and funding targets for the Ministry of Health Services and health authorities.
- Instituted a population needs-based funding formula for regional health authorities, so funding is allocated based on the relative needs of residents in each region.
- Introduced performance agreements between the Ministry of Health Services and health authorities which contain specific targets for system performance in key areas, such as emergency services, surgical services, mental health and addiction services, home and community care, population health, and Aboriginal health.
- Balanced budgets for the Ministry of Health Services and each health authority.

A critical step toward a population-based approach to care was the amalgamation of 52 diverse health authorities into five geographic authorities responsible for health services within their region and one provincial authority responsible for province-wide tertiary or highly specialized services. This streamlined structure is better able to manage the complexity of the health system, take advantage of the ability to adapt to change, make strategic investments across the continuum of care in order to be nimble, and be responsive to the changing needs of the population.

In 2004/05, the Ministry of Health Services continued with its health system reform efforts. While many of the major structural and governance changes have now been completed, many challenges remain. Even though British Columbians currently enjoy the best health status in Canada, there are worrying trends that are already creating unprecedented demands on the health system. Rising rates of obesity, a lack of physical activity, injuries, tobacco use and problematic substance use all impact individual health and create demands for health services. In addition, an aging population with a rising burden of chronic illness is resulting in the continuing rise in demand for increasingly complex and expensive health care services.

This annual report contains information on the ministry's key strategies and accomplishments in 2004/05, as well as performance results for system indicators. Significant reforms and new initiatives have continued across the health system, as the ministry works with health authorities and health professionals to build a system that meets the needs of British Columbians and is sustainable into the future.

Key Accomplishments in 2004/05

To support health reforms, and help meet rising demands for service, government once again increased health funding in 2004/05. Annual funding for health services has increased every year, and in 2004/05 more surgeries and more services were delivered in B.C.'s health system than ever before.

In September 2004, British Columbia played a leading role as the provinces and territories negotiated a new health deal with the federal government. As a result of this agreement, British Columbia expects to receive a total of $5.4 billion in new federal health funding over the next ten years. This new federal funding, which over 10 years represents approximately four per cent of the expected spending on health services, is not the panacea to our challenge of funding the health care system, but is an improvement to what B.C. would otherwise have faced.

While increased funding will help, government recognizes the system will not be sustainable, nor will it meet people's needs, unless it is redesigned to support good health and foster improved quality. The health system of the future must do more than provide short-term episodic care that is often based in a hospital. It must provide services across the continuum of care; services that help people stay healthy (health promotion and disease prevention), get better (intermittent use of primary, community and hospital care), manage disease or disability (chronic care), and cope with end of life (hospice/palliative care).

Accordingly, in 2004/05 the ministry introduced or continued a number of strategies across the span of health services, including population health and safety, primary care, chronic disease management, Fair PharmaCare, ambulance services, community programs for mental health and addictions, hospital and surgical services, home care, assisted living, residential care and end-of-life care. The ministry has also worked to ensure an adequate supply of skilled providers across all these programs.

Rebalancing the system to provide access to quality health care and services across one's life span will help improve the health of our population, ensure the right services are provided to meet people's needs, and assist in keeping the health system sustainable.

Keeping People Healthy

The health system has long been focused on treating people when they are sick or injured. While that is certainly a very important role for the system, it is also important that efforts be made to assist British Columbians to stay healthy. Good health enables people to enjoy their lives to the fullest and actively participate in society and the economy. In addition, investing in keeping people healthy reduces demand for expensive health care services and helps keep the system sustainable.

Accordingly, in 2004/05 the ministry introduced a number of innovative initiatives in the area of health promotion and disease prevention to improve the health and wellness of British Columbians. Efforts are being made to increase access to quality health information and support programs, and to provide services that prevent illness and disease. Highlights include:

- Launched ActNow BC, a program which cuts across all sectors to promote healthy lifestyles, prevent disease and mobilize communities by providing people with the information, resources and support they need to make healthy lifestyle decisions.
- Expanded Action Schools! BC to increase elementary students' physical activity levels and provide them with information on healthy lifestyles.
- Supported healthy childhood development by introducing programs to identify problems with hearing, vision or dental health for children before they reach Grade 1.
- Protected health through immunization programs, infectious disease and injury prevention and control measures, monitoring and regulating water and environmental safety, reproductive health, food security and health emergency management.
- Invested an additional $12.75 million in expanding childhood immunization programs for meningitis and chickenpox. Also, B.C. successfully met record demand for influenza immunization by providing well over 1,000,000 doses to B.C. citizens for the flu season.
- Strengthened prevention measures relating to West Nile virus through the addition of $5 million to ensure local mosquito control programs are in place. The ministry is working with the Provincial Health Officer, the BC Centre for Disease Control, health authorities and municipal governments to address the potential outbreak of West Nile.
- Continued to implement coordinated approaches for responding to major public health risks, emergencies or epidemics.

Providing Access to High Quality Care and Services

When people do get sick, they need access to health services to help them get better or manage their condition. The ministry, health authorities and health professionals have worked together to provide increased access to high quality services for British Columbians.

Increasing Access

Access has been expanded across the spectrum of care, from NurseLine services to heart surgery and cancer treatment. Highlights include:

- Increased overall funding for the health system to $10.7 billion, including an increase of $123 million to a record $6.2 billion for the province's six health authorities, to provide care and services that meets people's needs.
- Targeted over $45 million in additional funding to provide 240 more heart surgeries, 2,000 more orthopaedic procedures (including hip and knee replacements, arthroscopy and spine surgeries), 500 more cataract procedures and nearly 17,000 more diagnostic procedures. This builds on increased capacity built between 2001 and 2003, including a 21 per cent increase in hip replacements, 33 per cent increase in knee replacements, 20 per cent increase in cataract removals, and 40 per cent increase in angioplasties.
- Released B.C.'s first comprehensive survey of ER care — it revealed that 85 per cent of the over 14,000 patients surveyed rated the quality of care they received in B.C. emergency rooms as good to excellent. Also, almost 80 per cent reported waiting an hour or less to see the ER doctor.
- Added $20 million in new funding to B.C.'s cancer care system to improve radiation therapy services and increase cancer treatment access to stay ahead of demand for cancer services. Our cancer care network already contributes to B.C. having the best survival rates in Canada.
- Invested $3 million to increase the number of women having a screening mammogram every two years, a critical component of catching breast cancer early.
- Strengthened rural health services with a $6 million commitment for programs such as telehealth, recruitment programs, and improved ambulance services, and introduced a new rural travel assistance program to help eligible rural residents travel for medical services.
- Continued to expand the BC NurseLine service, which provides 24-hour, toll-free access to registered nurses specially trained to provide confidential health information and advice to citizens.
- Provided British Columbians with access to prescription drug coverage through the Fair PharmaCare plan, which focuses financial assistance on B.C. families who need it the most, with benefit levels based on a family's combined income. In January 2005, the program introduced a new monthly deductible payment option to further assist families in managing prescription drug costs.
- Led the charge on a National Pharmaceuticals Strategy to provide all Canadians access to catastrophic drug coverage, to accelerate access to breakthrough drugs, to strengthen the national evaluation of drug safety and effectiveness, and pursue national purchasing strategies to obtain drugs and vaccines at the best price possible. B.C. will continue to lead work on the strategy in 2005.
- Increased the threshold for eligibility for the Medical Services Plan premium assistance program by $4,000 per year. The change reduced or eliminated monthly payments for an estimated 215,000 British Columbians.

Improving Quality

Important initiatives have been undertaken across the health system to improve the quality of health services. Encouraging innovation, integrating services and applying proven best practices in the treatment of health conditions can all lead to better health outcomes for patients. Achieving system-wide quality improvement is not possible when individuals work alone, so many of the ministry's strategies have involved initiatives to share information and work together in the best interests of patients. Highlights include:

- Worked with physicians and health authorities to enhance primary care services. Through the 2004 working agreement with the British Columbia Medical Association, 30 Professional Quality Improvement Days involving approximately 800 physicians from across the province were held to provide opportunities for doctors, health authorities and the ministry to work together to enhance primary care services. Over 2,000 clinicians are now involved in primary care quality improvement initiatives across the province.
- Implemented innovative approaches for managing chronic diseases. A number of initiatives have been implemented, including a secure, web-based Chronic Disease Management Toolkit that gives authorized doctors, nurses and other care providers access to tools and information incorporating proven best practices for the treatment and management of chronic conditions.
- Invested $10 million to enhance patient safety. Among other initiatives linked to this investment is a $3 million one-time endowment to establish a research chair of patient safety at UBC's faculty of medicine and $6 million to support the work of a new Patient Safety Task Force.
- Provided $30 million to the Michael Smith Foundation for Health Research for new programs in B.C., which continue to develop, attract and retain outstanding health scientists and researchers. This funding supports research in priority areas such as health care re-engineering and innovation.
- Expanded emergency response services by having paramedics at ambulance stations 24 hours a day, in both rural and urban communities.
- Released *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction* that gives health authorities a common planning model to deliver comprehensive, responsive services from prevention through harm reduction and treatment.
- Continued the strengthening of mental health and addiction services across the province, including breaking ground on a 44-bed, $17 million psychiatric acute care facility at the Royal Inland Hospital to benefit patients in the Interior. The project is scheduled for completion by summer of 2005.
- Continued to implement a new model of home and residential care that expands options and better meets the needs of seniors. Government has added, replaced or upgraded over 4,000 residential care and assisted living units for seniors to date, and will complete 5,000 new residential care and assisted living spaces by 2008.
- Expanded end-of-life care choices, including the palliative benefits program that provides people who choose to die at home with medications, medical supplies and equipment.

- Invested in leading edge medical equipment, such as the first PET unit for B.C., to be located at the Vancouver Cancer Centre; new CT scanners for Royal Columbian Hospital, Royal Jubilee Hospital, Vancouver General Hospital, Lion's Gate Hospital and Kelowna General Hospital; and a new MRI scanner at Children's and Women's Hospital, a mobile MRI scanner for the Kootenays and South Okanagan, and an upgraded MRI scanner at UBC Hospital.
- Established an Electronic Health Steering Committee to accelerate the development and implementation of eHealth for British Columbia. A number of projects are underway, including development of an electronic health record, which will improve efficiency and safety by enabling care providers to access clinical information, such as patient medication profiles, lab and other testing results, using web-based technology.

Investing for Future Sustainability

Part of managing the system well is making the right strategic investments now that will help ensure our health system is sustainable into the future. Investing in infrastructure and health human resources are key priorities for government. Highlights include:

- Started construction of a new 300-bed Abbotsford Regional Hospital and Cancer Centre for the residents of the Fraser Valley, to be completed by 2008.
- Completed the Prince George Regional Hospital redevelopment, including a new patient care building with new medical/surgical beds, improved critical care services and a new emergency department.
- Redeveloped the Royal Inland Hospital in Kamloops, with a new emergency department opened and a new medical imaging department scheduled to be open in the summer of 2005.
- Began construction of the Nanaimo Regional General Hospital expansion to improve patient care, surgical services and maternal programs.
- Began the renovation and redesign of St. Paul's emergency department, due to be completed in 2005.
- Opened the 19-storey Jim Pattison Pavilion at Vancouver General Hospital, with 459 new beds and modern equipment and care facilities.
- Launched major improvements to the Fraser Valley Cancer Centre in Surrey and the Vancouver Cancer Centre to acquire and accommodate eight new and replacement linear accelerators.
- Started building a new 11-storey Academic Ambulatory Care Centre in Vancouver that will coordinate patient care services and academic programs in medical education, physician teaching clinics and research.
- Expanded B.C.'s medical training program, almost doubling the number of doctors in training. In September 2004, 72 more medical students than the previous year began their studies in B.C., bringing the total number of students in each year to 200. By 2008, there will be almost 900 medical students in training at any given time in B.C. Also, to strengthen medical education, government invested $27.6 million to expand and upgrade academic space in teaching hospitals around B.C.

- Strengthened government's relationship with physicians by reaching a new three-year working agreement. The agreement sets a framework for greater physician participation in health system issues like increasing physician use of information technology, supporting full service family practice and laboratory reform.
- Continued the Nursing Strategy to expand the number of nurses in B.C.'s health system. This year, an additional 321 seats were added to nursing programs, bringing the total number of new nursing seats to 2,134 since 2001. In addition, B.C.'s first group of nurse practitioners graduated in May 2005, adding a new and important level of care to the system.
- Entered an agreement to improve delivery of MSP and PharmaCare services to British Columbians and improve the protection and privacy of personal data.

Ministry Operating Context

The Ministry of Health Services operates within the broader societal and environmental influences on the population's health status. Enjoying good health and a high quality of life depends on many factors, including access to quality education, meaningful employment and stable family environments. Making healthy lifestyle choices is also important in optimizing the chance of good health.

Another influence on health status is access to high quality health services. British Columbians are supported in maintaining their health by a publicly funded health system, directed by the Ministry of Health Services and delivered primarily by B.C.'s health authorities and health care professionals. In the past 35 years, the scope of the public health system has expanded beyond traditional hospital and physician services to include comprehensive public health programs, a broad team of service providers, prescription drugs, home and community care and more.

Overall, British Columbians have a quality health system they can rely on and have some of the best health outcomes in the country. This is reflected in British Columbia's report on nationally comparable performance indicators entitled *Healthy British Columbia* released in November 2004. The report gives a broad snapshot of the health system and the health of the population in B.C. using 2003 data from the *Canadian Community Health Survey*. The report indicates British Columbians are mostly satisfied with their health care system, have good access to heath care, live healthier longer than other Canadians, are less likely to smoke than other Canadians and more likely than other Canadians to lead an active lifestyle. (The report can be found at http://www.healthservices.gov.bc.ca/cpa/publications/pirc_2004.pdf *)

Challenges and Risks

The ministry must monitor broader societal indicators and trends to assess and plan for potential impacts on the health of the public and the health care system. For instance, while British Columbians currently enjoy the best health status in Canada, there are worrying trends that are already creating unprecedented demands for health services:

- 42 per cent of adult British Columbians are overweight or obese according to self-reported data, and only 58 per cent are physically active or moderately active.
- Injuries continue to be the leading cause of death for British Columbians age one to 44, with injuries killing more children and young adults than all diseases combined.
- Tobacco use remains the risk factor that most contributes to the burden of diseases in British Columbia, but problematic substance use is also a concern. 19 per cent of youth who attend school and have tried alcohol reported binge drinking three or more times in the past month.
- An aging population with a rising burden of illness is resulting in the continuing rise in demand for increasingly complex and expensive health services.

* *Refer to note on page 3.*

- The health care workforce is aging, and maintaining an adequate supply and mix of health professionals and workers will be challenging.

As noted, population growth and demographic shifts put pressure on the health system as different health services tend to be used at higher rates in older age groups. The following demographic trends help to illustrate the scope of the future challenge to the health system:

- British Columbia's population is growing; in 2004 the population increased by 44,094 persons and is expected to increase by 41,670 persons in 2005, 44,472 in 2006 and 46,467 in 2007. In 2001 B.C.'s population was 4,078,447. By 2007 it is forecast to be 4,317,613, an increase of 5.9 per cent.
- The share of British Columbia's population over the age of 65 is expanding; relative to 2005, there will be 35 per cent more people over 65 by 2015, 20.5 per cent more over 75, and 45 per cent more over 85. The median age in British Columbia is 39.6 years, and is expected to reach 41.9 years by 2015. Expenditures on health increase with age.
- Life expectancy is increasing. In 2005, the median age at death was 79 years and by 2015, the median age at death will be 80.6 years.

In addition, the health system is also challenged by:

- A need to update or expand health care facilities, technology and equipment.
- The development of new treatments for patients with conditions that were previously untreatable.
- The emergence of new diseases, which result in new tests, drugs and treatments.
- Public health emergencies such as SARS, Avian flu, and West Nile Virus.

Capacity to Manage Risks

Government has annually increased funding for health services; however, funding increases alone will not meet the increasing and changing demands placed on the health system. As shown in this annual report, and the ministry's 2005/06 – 2007/08 service plan, the ministry has undertaken many strategies to ensure the health system is able to adapt and respond to changing demands.

A key to realizing these reforms and building a system that will remain sustainable in the face of the many challenges has been to strengthen the ministry's relationship with its health system partners. Our capacity to respond to change has been greatly increased through the development of an accountable, efficient and responsive health sector that welcomes the challenge of improving services for the citizens of British Columbia. The new model for health care is driven by one principle — people must come first. Where success had previously been measured by the amount of money spent, the number of beds available or the number of health professionals working in the system, success in meeting our challenges is now measured in terms of accessibility, health outcomes and overall health status.

Ministry Role and Services

The Ministry of Health Services provides leadership, support and funding for British Columbia's health system, and works with B.C.'s health authorities and other system partners to deliver quality, appropriate and timely health services. The ministry primarily acts as steward of the system by setting immediate and long-term direction through strategic planning; developing legislation, policy and standards; and monitoring, evaluating and reporting on system performance and taking corrective action when necessary. Health authorities and other providers (e.g., physicians) directly deliver the vast majority of health services to the public, although the ministry still delivers some services such as the B.C. Ambulance Service and the Vital Statistics Agency.

Vision, Mission and Values

Vision

A health system that supports people to stay healthy, and when they are sick provides high quality publicly funded health care services that meet their needs where they live and when they need them.

Mission

To guide and enhance the province's health services to ensure British Columbians are supported in their efforts to maintain and improve their health.

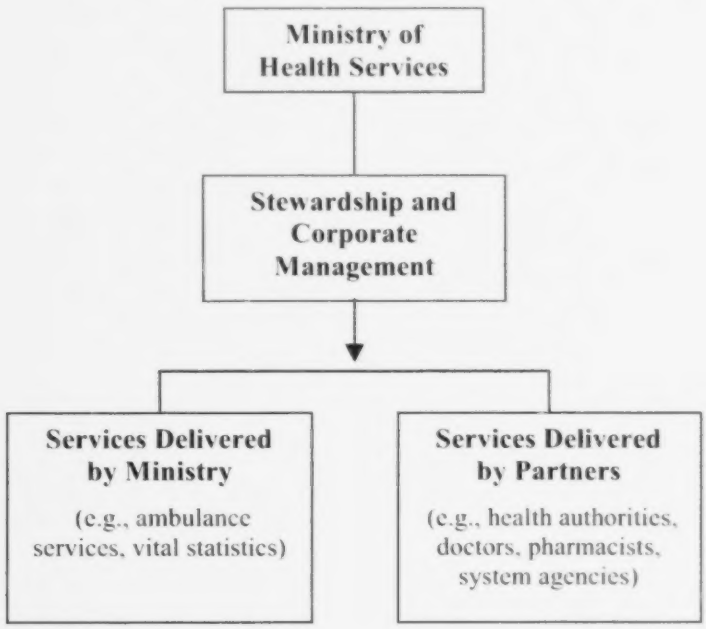
Values

A set of beliefs, consistent with the principles of the *Canada Health Act*, defines our organizational behaviour:

- **Citizen and patient focus** which respects the needs and diversity of all British Columbians.
- **Equity** of access and in the quality of services delivered by government.
- **Access** for all to quality health services.
- **Effectiveness** of delivery and treatment leading to appropriate outcomes.
- **Efficiency,** providing quality, effective, evidence-based services in a cost effective way.
- **Appropriateness,** providing the right service at the right time in the right place.
- **Safety** in the delivery of health services to minimize risks to the health and safety of British Columbians.

Core Business Areas for the Ministry of Health Services

The core business areas of the ministry are organized to reflect the different roles in the health system. Accordingly, the ministry has three broad core business areas: *Services Delivered by Partners, Services Delivered by Ministry,* and *Stewardship and Corporate Management*.


Ministry of Health Services
Stewardship and Corporate Management
Services Delivered by Ministry
(e.g., ambulance services, vital statistics)
Services Delivered by Partners
(e.g., health authorities, doctors, pharmacists, system agencies)

Details of the key functions and responsibilities of each of these core businesses can be found in Appendix C.

Summary Report on Performance

The Ministry of Health Services has made a strong commitment to transparent performance reporting in the health sector, and has been working with health authorities and agencies, such as the Canadian Institute for Health Information, to develop meaningful performance indicators and ensure quality data are available. In addition to the ministry's Annual Service Plan Report, a number of other performance reports are now produced, including the Provincial Health Officer's Annual Report, the Annual Report on Health Authority Performance, British Columbia's Report on Nationally Comparable Indicators and the Vital Statistics Annual Report.

Performance reporting in this annual report is focused on the objectives, strategies and performance measures contained in the ministry's 2004/05 – 2006/07 Service Plan. The ministry's strategic focus has been, and continues to be, in support of government's priorities and the ministry's three overarching goals:

Government's Strategic Priorities Related to the Ministry

- British Columbians will be healthy
- B.C. will have a healthy physical environment
- Government will be affordable and fiscally responsible

↓

Ministry Goals

- Improved Health and Wellness for British Columbians
- High Quality Patient Care
- A Sustainable, Affordable Health Care System

Performance reporting indicates progress toward meeting these goals and priorities. The table on the following pages provides a synopsis of the ministry's key performance results for 2004/05.

Overview of Ministry Results

Overall, the ministry has performed well in achieving its performance targets. The following table gives an overview of results for 29 key performance measures used to judge progress on the ministry's key objectives and priority strategies as outlined in previous service plans. Detailed reporting of these results, including historical data and results analysis, can be found in Appendix A: Report on Performance.

At the time of publication not all performance measures have complete data available for 2004/05. When complete data is not available, the ministry uses the most recent data available to assess its progress. In the following table, measures listed as *"Achieved"* include those that have met the 2004/05 targets, and those that are expected to meet the targets based on partial year data from 2004/05. Measures listed as *"Substantially Achieved"* are those where results indicate the ministry has achieved significant progress, either within 2004/05 or across the three years ending 2004/05.

Performance measures listed in the table as *"Trend on Track"* are those where no 2004/05 data is available but where the most recent data available indicate the ministry is making progress toward the 2004/05 target. Performance measures that have not been achieved and require more work and are listed as *"Not Achieved"*.

Of the 29 performance measures used to judge progress on the ministry's key objectives, 24 have results that achieved or substantially achieved the target. An additional four performance measures show trends that are on track to achieve the targets, and one measure did not achieve the target and requires further attention. These results indicate the ministry has made good progress in re-aligning the system to provide care in the appropriate setting, has increased access to higher quality care, and improved the efficiency and management of the health system.

The ministry has also undertaken a number of strategies to meet objectives within its stewardship and corporate management role. Accordingly, the following table also includes 14 performance measures identified for those objectives and strategies. All but one of those performance measures was either achieved or substantially achieved in 2004/05. Detailed reporting on the stewardship and corporate management strategies can also be found in Appendix A.

Synopsis of Ministry Results

Ministry Goals	Ministry Key Objectives	Measure	Result
High Quality Patient Care.	1. Provide care at the appropriate level in the appropriate setting by shifting the mix of acute/ institutional care to more home/ community care.	1. Rates of admission for conditions that could be managed outside hospital (conditions classified as "may not require hospitalization").	Substantially Achieved
		2. NurseLine use rates.	Achieved
		3. Percentage of days spent by patients in hospitals after the need for hospital care ended, measured by alternate level of care days (ALC days) as a percentage of total hospital inpatient days.	Substantially Achieved
		4. Percentage of clients with high care needs living in their own home rather than a facility.	Substantially Achieved
		5. a) Waiting times for Radiotherapy.	Achieved
		5. b) Waiting times for Chemotherapy.	Achieved
		6. Emergency Room Use.	Achieved
		7. Improved continuity of care measured by the proportion of persons (aged 15 to 64) hospitalized for a mental health diagnosis who receive community or physician follow-up within 30 days of discharge.	Achieved
		8. Improved availability of community services measured by the percentage of days spent by mental health patients (aged 15 to 64) in hospital after the need for hospital care ends.	Achieved
		9. Proportion of mental health services (community, physician and acute care) received by mental health clients (aged 15 to 64) that are obtained in their own health authority.	Substantially Achieved

Ministry Goals	Ministry Key Objectives	Measure	Result
High Quality Patient Care *(continued)*.	2. Provide tailored care for key segments of the population to better address their specific health care needs and improve their quality of life.	10. Percentage of days spent by highest needs patients in hospitals after the need for hospital care ended, measured by alternate level of care days (ALC days) as a percentage of total hospital inpatient days for these patients.	Substantially Achieved
		11. Adherence to clinical best practices for managing chronic diseases measured by percentage of full-service family physicians claiming payment for treating patients according to evidence-based guidelines.	Achieved
		12. Prescription rates for: a) ACE inhibitors and b) Beta blockers for congestive heart failure patients.	Trend on Track
		13. Percentage of patients in B.C. accessing home-based PharmaCare Palliative Plan in the 12 months prior to death.	Substantially Achieved
		14. a) Aboriginal peoples infant mortality.	Trend on Track
		14. b) Aboriginal peoples life expectancy.	Trend on Track
Improved Health and Wellness for British Columbians.	3. Keep people as healthy as possible by preventing disease, illness and disability and slowing the progression of chronic illness to minimize suffering and reduce care costs in the future.	15. The percentage of patients with diabetes who undergo at least two HbA_{1c} tests per year.	Trend on Track
		16. a) Two-year olds with up-to-date immunizations.	Not Achieved
		16. b) Influenza immunization for residents of care facilities.	Achieved
A Sustainable, Affordable Health Care System.	4. Manage within the available budget while meeting the priority needs of the population.	17. Develop patient safety programs and performance measures.	Achieved
		18. Spending on administrative and support services by health authorities.	Achieved
		19. Health authorities in a balanced budget position in each fiscal year.	Achieved

Ministry Goals	Ministry Key Objectives	Measure	Result
High Quality Patient Care.	5. Provide clients with equitable and timely access to services directly delivered by the ministry.	20. Ambulance service response rates.	Achieved
		21. Percentage of population adequately insured against catastrophic prescription drug costs.	Substantially Achieved
		22. Turnaround times for MSP beneficiary services to the public: (a) Enrolment applications.	Achieved
		22. b) Premium assistance applications.	Achieved
		23. Vital Statistics registration turnaround times.	Achieved
		24. Vital Statistics customer and client satisfaction rates.	Achieved
		25. Expand scope of clients having access to Vital Statistics VISTA data warehouse.	Achieved

Stewardship and Corporate Management

Ministry Goals	Ministry Key Objectives	Measure	Result
High Quality Patient Care. Improved Health and Wellness for British Columbians. A Sustainable, Affordable Health Care System.	1. Direction: Government's strategic direction is clearly defined and communicated and guides service delivery.	1. Mid- and long-term direction setting plans for the health sector completed.	Substantially Achieved
		2. Health authorities' ratings of the clarity, timeliness and usefulness of government direction in guiding service delivery.	Substantially Achieved
		3. Strategic clinical practice guidelines/ standards in priority areas developed and implemented.	Achieved
		4. Priority programs developed for prevention and protection.	Substantially Achieved
		5. Improved governance and accountability framework developed for the health professions.	Achieved
	2. Support: Supports are in place to facilitate the achievement of strategic priorities, and barriers to change have been removed.	6. Health authorities' ratings of data availability and usefulness in supporting planning and service delivery.	Substantially Achieved
		7. Percentage of regulatory requirements reduced.	Achieved
		8. Health human resource, IT, and Capital plans developed.	Substantially Achieved
	3. Monitoring, Evaluation and Course Correction: Delivered services meet public needs and are sustainable.	9. Health authority performance agreements signed.	Substantially Achieved
		10. Overall health system financial status (actual expenses compared to budgeted expenses at year end).	Achieved
		11. Report annually on population health status or a significant health issue.	Achieved
		12. Percentage of employees who indicate comprehension of the vision, mission and goals of the organization and their role in assisting to achieve these goals.	In Progress
		13. Percentage of divisions with integrated service and HR plans.	Achieved
		14. Percentage of divisions with risk management plans.	Substantially Achieved

New Era Commitments

Over the past four years the Ministry of Health Services has been implementing the government's *New Era* commitments for the health system. Many of those commitments, such as implementing performance agreements with health authorities, have now become an ongoing part of the ministry's operations.

The *New Era* commitment to build 5,000 residential care and assisted living beds is underway, but requires more work in the coming years. The province is developing new residential care beds, supportive housing and assisted living spaces to ensure seniors and people with disabilities have a range of housing and care options appropriate to their individual needs. This commitment is currently underway with a revised timeline.

To date, we have built or renovated over 4,000 units. These units include a portion of 3,500 additional independent living spaces for seniors and persons with disabilities through Independent Living BC, built in co-operation with nonprofit, community, municipal and federal partners through the Independent Living BC program. This also includes an extensive program of replacements and renovations for residential care to modernize outdated facilities (some more than 30 years old) and ensure 24/7 quality care for patients with complex care needs. While this emerging need to replace aging stock on top of adding new stock has created challenges, by December 2006 we will be more than halfway to meeting our commitment, and will meets its final goal by the end of 2008.

Summary Report on Resources

B.C.'s health services budget has continued to grow and it is important this funding is used wisely to provide the best care and achieve the best outcomes for patients, and that all parts of the system manage within their allocated budgets. The ministry monitors financial status throughout the year so any problems can be identified and addressed, and ensures overall costs remain within its budget.

The Ministry of Health Services 2004/05 budget was $10.71 billion (includes *Estimates* and *Supplementary Estimates*). The actual spending for the fiscal year ended March 31, 2005 totaled $10.67 billion, resulting in an operating surplus of $40 million, which represents 0.4 per cent of the budget. In addition, an accounting adjustment to reverse prior year accruals of $60 million was credited to the ministry budget as a year-end adjustment. Accrual reversals are a normal part of accounting practices, however, in prior years these adjustments were applied to the Consolidated Revenue Fund and were unavailable to the ministry for spending. A change in accounting practice in 2004/05 resulted in these adjustments being credited to the ministry budget; however, once again they were not available to the ministry to spend. This adjustment results in a total ministry surplus of $100 million.

The following table provides an overview of financial results for 2004/05. A full Report on Resources can be found in Appendix B.

	Total Estimated	Actual	Variance (Actual minus Total Estimated)[1]	% of Budget
Operating Expenses ($000)				
Operating Expenses	**10,706,431**	**10,666,381**	**(40,050)**	**0.4%**
Adjustment of Prior Year Accruals[2]		(59,943)	(59,943)	
Total — Ministry of Health Services			**(99,993)**	**1.0%**

[1] Variance display convention has been changed this year to be consistent with the change introduced in public accounts. Variance is in all cases "Actual" minus "Total Estimates". Where the Actual is greater the Variance is displayed without brackets

[2] Adjustment of prior year accruals. Amounts reflect adjustment of prior year's expense accruals which were credited to revenue and therefore not available for the ministry to spend. In 2004/05 the adjustment was credited to ministry expense and again was not available for spending.

Appendix A: Report on Performance

The ministry's 2004/05 – 2006/07 Service Plan contained a number of objectives and strategies designed to move the health system toward reaching the ministry's goals. This appendix provides details of the progress in 2004/05 on those reform strategies. The following pages report progress on the ministry's objectives and strategies, as well as actual results of performance compared to the targets set out in the 2004/05 – 2006/07 Service Plan.

For the purpose of this annual report, the availability of timely data remains a challenge. For example, measures that report on hospital performance have a lag between the moment an event occurs and the time when data generated from that event is collected, checked and assembled in a usable format. Generally, the movement of hospital data through the system takes three months; however, because the measures in this report are at a provincial level, the ministry must wait for all hospitals to submit data. Because some data can take up to six months to report, it is impossible to have complete data for all measures by the Annual Service Plan Report publication date. The ministry is working with health authorities to improve the availability of quality data in the future.

Some measures in this report do not have data for 2004/05. Where partial data is available for that period, it is reported; where none is available, the most recent year's data is reported. Performance reporting shows results over several years to illustrate trends and provide context for recent results. Given the size and scope of the health system, viewing results over time gives a clearer, broader indication of performance in a given area.

Results

Core Business: Services Delivered by Partners

The core business, Services Delivered by Partners, comprises the majority of health services delivered to the public. These services span beginning to end-of-life care, health promotion to disease prevention, and primary to acute care. In the 2004/05 Service Plan the ministry identified four objectives under this core business. To achieve these objectives, the ministry works closely with those health care partners that deliver services directly to the public.

Goal: High Quality Patient Care

Objective 1: Provide care at the appropriate level in the appropriate setting by shifting the mix of acute and institutional care to more home and community care.

Our hospitals, community services and health care professionals must be used in the most effective and efficient way possible to lead to the best patient outcomes.

B.C.'s health authorities are the ministry's key partners in changing the structure of the health system. Health authorities have been given the managerial scope to implement large-scale structural changes to how health care services are delivered. These redesign efforts, which were begun in 2001 and are still underway in communities throughout B.C., are shifting the mix of services and health care providers to ensure care is delivered at the most appropriate level and setting. The goal is to create an integrated network of services, which links primary care, diagnostics, home and community care and acute care. In an integrated system the patient will move more easily between various settings and providers, and will not be left waiting at one level for services to be provided at another.

Priority Strategy 1: Hospital Admissions Prevention through Increased Community Care Options: Prevent unnecessary hospitalizations by providing patients with better access to family physicians, specialists, other providers and services in the community.

Many patients who are admitted for treatment to a hospital could receive appropriate care in a less intensive setting. The ministry, health authorities and care providers are working together to improve access to family physicians and other community resources so people can get the care they need, without unnecessary hospitalization.

Enhancing primary care is the key to achieving this strategy. Primary care is a patient's first and most frequent point of contact with the health system and supports individuals and families to make the best decisions for their health. Patients access primary care when they visit their doctor, medical clinic, or public health unit. Between 2002 and 2006, B.C. has been allocated $74 million from the Health Canada Primary Care Transition Fund to make improvements in primary care. Most of this funding has supported health authorities' initiatives in providing more comprehensive, accessible primary health care services. Regional initiatives include:

- primary health care organizations;
- networks linking family practices;
- community health centres;
- shared care arrangements providing family practices with specialist consultation and expertise;
- nurse managed care in regions with limited access to physicians; and
- chronic disease management.

Good progress has been made. Through the 2004 working agreement with the British Columbia Medical Association, 30 Professional Quality Improvement Days involving approximately 800 physicians from across the province have been held to provide opportunities for doctors, the province and health authorities to work together to enhance primary care services. Over 2,000 clinicians are now involved in primary care quality improvement initiatives across the province.

To provide 24-hour health resources to all British Columbians province-wide, the ministry also continues to expand the BC HealthGuide Program, giving B.C. residents access to

medically approved health information and advice 24 hours a day, seven days a week. This program consists of a 400-page BC HealthGuide Handbook, a companion First Nations Health Handbook, a comprehensive website at http//www.bchealthguide.org*, the BC NurseLine and pharmacist services, and the BC HealthFiles. More information on the BC NurseLine can be found under Performance Measure 2.

PS — Performance Measure 1: Rates of admission for conditions that could be managed outside hospital (conditions classified as "may not require hospitalization").

This rate helps identify opportunities to more efficiently manage resources by focusing expensive, specialized hospital care on those who truly need it, and treating less acute cases in a more cost-effective and clinically appropriate manner. Specifically, when patients are admitted to hospital they are classified into case groups based on their diagnosis. One of these groups is "may not require hospitalization" (MNRH). Asthma and hernia are among the conditions that fall under this category — conditions which can be treated without admission to hospital.

This performance measure helps the ministry assess success of the first part of priority strategy one, to prevent unnecessary hospitalizations.

Results

2004/05 Target	2004/05 Actual[1]	Status
5% decrease over prior year	N/A	Substantially Achieved

	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05[1]
Annual Target			Baseline	-5.0%	-5.0%	-5.0%
MNRH Rate (cases/1,000 pop)	7.9	7.0	5.9	5.2	5.3	n/a
→ % change from previous year		-11.7%	-15.5%	-10.7%	0.1%	

[1] 2004/05 — data not available.

DATA SOURCE: Discharge Abstract Database (DAD), November 26, 2004, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services. Population Extrapolation for Organizational Planning with Less Error (P.E.O.P.L.E. 29), BC Stats, BC Ministry of Management Services; Health Data Warehouse, BC Ministry of Health Service.

NOTES: Data should be interpreted with caution.

MNRH CMGs, starting with the fiscal year 2001/02, are inconsistent with MNRH CMGs of previous years, an effect of the move to ICD10CA (International Classification of Diseases, Tenth Revision, Canada) and CCI (Canadian Classification of Interventions) from ICD9 and CCP. The Canadian Institute for Health Information (CIHI) is working on this issue and has cautioned against the use of CMGs for the years 2001/02 onward until the problem is resolved.

Analysis: No data are available for 2004/05. Data for 2003/04 show the MNRH rate remained stable compared to 2002/03; however, taking a longer view of performance shows B.C. has been successful in lowering the MNRH rate as it has declined over 10 per cent since 2001/02. This decrease has been achieved within the context of B.C. already having

* *Refer to note on page 3.*

the lowest MNRH rate in Canada (based on national data for 2001/02, the latest for which MNRH is available).

It is important to note that a target rate of zero MNRH cases is unrealistic. In some instances, a patient's clinical condition and/or patient safety issues that may be taken into account by the admitting physician may well justify admission to hospital, even though the diagnostic coding indicates MNRH. Instead, the idea is to avoid a high, or steadily increasing rate of hospitalization for MNRH conditions, as that would signal problems in the delivery of care at the primary level.

The MNRH measure was originally selected in 1999 through the National Consensus Conference on Population Health Indicators as a way to monitor the strength of the primary care system. Since then, a new measure called Ambulatory Care Sensitive Conditions (ACSC) has emerged to perform this monitoring function and has replaced MNRH at the national level as it better reflects the rising importance of chronic disease treatment in the primary care sector. To stay nationally relevant, and because of strong performance in MNRH rates, in 2005/06 B.C. will switch to monitoring ACSC rates in its performance agreements with health authorities.

PS — Performance Measure 2: BC NurseLine use rates.

British Columbians can call the 24-hour BC NurseLine toll-free and speak with registered nurses specially trained to provide confidential health information and advice on the telephone. The nurses help callers understand and manage health concerns, get health information on home treatment and other care options, and get advice on when to see a health professional. BC NurseLine answers questions about various health topics, tests and medical procedures, and provides information on other community resources. BC NurseLine also provides a pharmacist service from 5 p.m. to 9 a.m. daily to answer medication-related calls. The number of calls to BC NurseLine helps gauge whether British Columbians are accessing health resources that may reduce demand on hospitals and physicians.

Results

2004/05 Target	2004/05 Actual	Status
60% increase over baseline 02/03 (172,934 calls)	91.7% increase over baseline	Achieved
150% increase in calls transferred from physicians' offices over baseline 02/03 (1,423 calls transferred)	461.6% increase in calls transferred from physicians' offices over baseline	Achieved

		FISCAL YEAR			
		2001/02	2002/03	2003/04	2004/05
Call Volume	**Target**		Baseline	35.0%	60.0%
Call Volume		103,471	172,934	250,018	331,429
→ % change in call volume over baseline				44.6%	91.7%
Calls transferred from physicians' offices	**Target**		Baseline	100.0%	150.0%
Calls transferred from physicians' offices		335	1,423	7,251	7,991
→ % change in calls transferred over baseline				409.6%	461.6%

DATA SOURCE: BC NurseLine Call Manager Database, April 5, 2005, BC HealthGuide Program, Population Health and Wellness, Ministry of Health Services.

DEFINITIONS:

Call Volume: total number of incoming calls to the BC NurseLine during the fiscal year.

Number of calls transferred from physicians' offices: callers state that they received the BC NurseLine number from a physicians' office or walk-in clinic ("Doctor/Walk in clinic" response in Call Prompt field in Call Manager).

Analysis: Since it began operating in Spring 2001, BC NurseLine has grown very rapidly. This is attributable to ongoing promotion in government publications; its consistent, 90 per cent plus customer satisfaction, which leads to both good word-of-mouth and repeat callers; and the use of NurseLine as the point of contact in managing public information for public health issues such as SARS, forest fires, West Nile Virus, Avian Flu, and flu campaigns.

An important aspect of NurseLine, captured in the second part of the measure (calls transferred from physicians' offices), is its role as after-hours support for physicians and walk-in clinics. Though up substantially from 2001/02, the growth rate in the number of forwarded calls slowed in 2004/05. This is likely due to the absence of a sustained communications campaign targeting health professionals, an element that will be explored as part of future BC HealthGuide Program education and promotion strategies.

Priority Strategy 2: Post-Acute (hospital care) Alternatives: Provide appropriate community health support to enable timely discharge of patients from hospital once the need for acute medical care has ended.

Patients may remain in hospital longer than necessary for various reasons, including lack of available room in a residential facility or lack of community services to support discharge from hospital. The ministry and health authorities have been working to ensure the right mix of services is available so patients can access appropriate services once the need for hospital care has ended. This will result in better care for patients and better use of health system resources.

PS — Performance Measure 3: Percentage of days spent by patients in hospitals after the need for hospital care ended, measured by alternate level of care days as a percentage of total hospital inpatient days.

This measure indicates whether patients have timely access to appropriate care in the most appropriate setting. The days patients spend in hospital after the need for acute care has ended are called alternate level of care (ALC) days. A reduction in ALC days means more appropriate care is being delivered to patients, resulting in more acute care hospital beds being available for those who need acute care.

Results

2004/05 Target	2004/05 Preliminary*	Status
5% decrease over prior year	3.8% increase	Substantially Achieved

	FISCAL YEAR					
	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05*
Annual Target			Baseline	-5.0%	-5.0%	-5.0%
ALC Days	379,930	424,922	387,978	338,607	301,936	201,880
Inpatient Days	2,750,756	2,730,866	2,612,699	2,548,797	2,562,749	1,651,174
% ALC Days	13.8%	15.6%	14.8%	13.3%	11.8%	12.2%
→ % Change in % ALC Days from previous year		12.7%	-4.6%	-10.5%	-11.3%	3.8%

* 2004/05 - partial year data.

DATA SOURCE: Discharge Abstract Database (DAD), April 7, 2005, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services.

NOTES: Riverview Hospital only started reporting in the DAD as of 2002/03. The data in this report will vary from previous versions of this report for 2002/03.

Analysis: Based on data to December 31, 2004, the province does not expect to see further decreases in the ALC rate for 2004/05. However, the health system has made significant

reductions in ALC rates over the past few years — the 2004/05 preliminary results still show an 18 per cent decrease in the ALC days rate since 2001/02.

Over the past four years the province has lowered ALC days with a combination of strategies. For example, the move to five regional health authorities in 2001 has allowed for better co-ordination of residential care beds across each region, and a more efficient movement of patients between the acute and residential care setting. In addition, health authorities have added sub-acute, hospice and convalescent care beds to the continuum of care for patients that require a rigorous, but not acute, level of care.

Moving forward, health authorities will continue to monitor ALC days and implement ALC reduction strategies.

Priority Strategy 3:	**Effective Management of Acute Care Services in Hospitals: Plan for and manage the demand on emergency health services and surgical and procedural services.**

While most of the strategies under this objective are focused on providing services outside the hospital, this strategy focuses on ensuring needed hospital services are provided in a timely and high quality manner. Under this strategy, the ministry and all six health authorities have participated in two province-wide projects to improve access to, and effectiveness of, emergency room and surgical services in hospitals across the province.

Government has also made targeted investments to reduce waiting times in key areas for British Columbians. Over $45 million in additional funding was allocated to provide 240 more heart surgeries, 2,000 more orthopaedic surgeries (including hip and knee replacements, arthroscopy and spine surgeries), 500 more cataract procedures and nearly 17,000 more diagnostic procedures. This builds on increased capacity built between 2001 and 2003, including a 21 per cent increase in hip replacements, 33 per cent increase in knee replacements, 20 per cent increase in cataract removals, and 40 per cent increase in angioplasties.

PS — Performance Measure 5: Waiting times for key services:

a) Radiotherapy.

b) Chemotherapy.

Monitoring wait times for these key services helps ensure patients' cancers are treated as early as possible to achieve the best outcomes. This indicator measures the percentage of patients that begin radiotherapy within four weeks of being ready to treat and the percentage of patients who start chemotherapy within two weeks of being ready to treat.

Results

2004/05 Target	2004/05 Actual	Status
a) Maintain at 90% of radiotherapy patients begin treatment within 4 weeks	95.5%	Achieved
b) Maintain at 90% of chemotherapy patients begin treatment within 2 weeks	90%	Achieved

DATA SOURCE: Provincial Radiation Therapy Program, 18 April 2005, BC Cancer Agency.

Analysis: Over 10,000 patients receive radiation therapy treatment each year in B.C. The BC Cancer Agency (BCCA), provider of all radiation therapy treatment, has exceeded the 2004/05 target by providing treatment to 95.5 per cent of patients within four weeks of being ready to treat, defined as the time between a medical oncologist determining a patient is ready for radiation therapy, and that patient receiving it.

In addition, the ministry and BCCA track the other component of a patient's wait: from the family doctor's referral to an oncologist to the patient's first appointment with the oncologist. The median wait here was 12 days.

It should be noted that because data for this measure is from the BCCA scheduling system, not all patients are captured. The most urgent patients never show up on the scheduling system as they receive treatment immediately.

BCCA continues to place a high priority on providing timely access to radiotherapy and has consistently increased the percentage of clients beginning radiotherapy within four weeks of being ready to treat over the last four years.

Chemotherapy

For chemotherapy, the BCCA has a standard in place that patients will receive therapy within 14 calendar days of the physician's order being written. The BCCA has confirmed to the ministry that patients in BCCA centres are being treated within the standard in 90 per cent of cases.

In B.C., about half of all chemotherapy treatments are provided in therapy clinics residing within community hospitals and the other half is provided in chemotherapy centres managed by the BCCA. The Provincial Systemic Therapy Program began the process of collecting chemotherapy wait time statistics from the clinics and centres in 2004/05. Accordingly, future performance reports will be able to report detailed and comparable data.

Currently, British Columbia has excellent cancer outcomes, and leads Canada in survival rates for most cancers.

PS — Performance Measure 6: Emergency Room Use performance measure.

The ministry and all health authorities have been working together to improve the quality and performance of emergency department services across the province. In 2003/04,

the Provincial Emergency Services Project (PESP) released the Emergency Services Short-term Task Group Progress Report — the report is available at http://www.phsa.ca/AgenciesServices/Services/pesp.htm *on the Provincial Health Services Authority website. All health authorities are making progress in implementing recommendations from that report.

In 2004, the ministry released its first comprehensive survey of Emergency Room care. The results revealed that 85 per cent of the over 14,000 patients surveyed rated the quality of care they received in B.C. emergency rooms as good to excellent. Almost 80 per cent reported waiting an hour or less to see the ER doctor. The full survey report can be found at http://www.mediaroom.gov.bc.ca/Download.axd?objectId=138 *.

2004/05 Target	2004/05 Actual	Status
Develop Emergency Room Use performance measure	Measure developed	Achieved

Analysis: The ministry's 2005/06 - 2007/08 Service Plan includes a measure related to emergency room use: *the proportion of patients admitted from an emergency department to an inpatient bed within 10 hours of the decision to admit.*

Hospital admissions can either be planned, such as scheduled surgery, or unplanned. This new measure focuses on unexpected hospital admissions that occur through hospital emergency departments. Many people are appropriately treated and released from emergency departments, but some require an extended course of treatment and must be admitted to hospital. Measuring the amount of time from the decision to admit a patient from an emergency department to when the patient is admitted to an inpatient bed will provide an indication of access to appropriate levels of care.

Priority Strategy 4: Alternatives to Institutional Care: Help elderly and disabled individuals avoid institutionalization and remain as independent as possible in their own homes and communities by increasing the range of supportive housing environments and community care options, while reserving residential institutions for patients with the most complex care needs.

Over the last four years, health authorities have been implementing redesign strategies to shift the balance of care from traditional residential care facilities to home and community options such as assisted living. This new model of care will better meet the needs of clients and their desire for more autonomy as they age. It will also help make the health system more sustainable by focusing resources on providing appropriate care in the appropriate setting, rather than simply admitting the elderly or disabled to facilities designed for complex care.

A significant achievement has been the full implementation of a new access policy for residential care. The policy eliminated long wait lists by ensuring only those people who

* *Refer to note on page 3.*

meet established criteria and require complex care are admitted to a residential care facility. To ensure more efficient use of residential care beds, health authorities have established priority access systems that coordinate the use of beds throughout each region, resulting in faster transitions from acute care to the appropriate care setting.

In 2004/05, health authorities continued to expand home and community care options to meet the diverse needs of seniors and the disabled. Services include assisted living, adult day centres, home support, professional home care nursing and community rehabilitation services, and end-of-life care.

PS — Performance Measure 4: Percentage of clients with high care needs living in their own home rather than a facility.

This indicator tracks the percentage of seniors and people with disabilities who have high care needs and receive home support or adult day care services to allow them to remain more independent. Evidence indicates more people can and want to remain at home for as long as possible if they have appropriate support. This improves quality of life and frees up residential care beds for those with more complex care requirements.

Results

2004/05 Target	2004/05 Preliminary*	Status
5% increase over prior year	2.5% increase	Substantially Achieved

	POINT IN TIME					
	1999/00 31 Mar. 00	2000/01 31 Mar. 01	2001/02 31 Mar. 02	2002/03 31 Mar. 03	2003/04 31 Mar. 04	2004/05* 31 Dec. 04
% of clients — Annual Target			Baseline	2.0%	2.0%	5.0%
Total Number of high needs clients	43,023	44,223	44,076	43,234	43,353	43,922
# of clients receiving care at home	18,763	19,477	19,277	19,503	20,427	21,207
% of clients receiving care at home	43.6%	44.0%	43.7%	45.1%	47.1%	48.3%
→ Change in % of clients at home from previous year		1.0%	-0.7%	3.1%	4.5%	2.5%

* 2004/05 — partial year data (point in time at Dec. 31, 2004).

DATA SOURCE: CCData Warehouse, March 2005 refresh, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services.

NOTES: Only clients assessed at IC2, IC3 or EC are included in the report. Data for clients receiving care at home includes Adult Day Care, Home Support, CSIL, and Assisted Living authorized by LTC Case Management or Mental Health. Data for clients receiving care in a facility includes those in residential facilities, group homes, family care and transitional care units authorized by LTC Case Management. Respite care is excluded. Clients are counted uniquely at each level. You cannot sum the HSDA counts to obtain the HA count, nor can you sum the HA counts to obtain the BC count.

Analysis: Based on preliminary 2004/05 data, there continues to be an increase in the proportion of high needs clients being cared for in the community rather than a facility. Going back to 2001, there are now 10 per cent more high needs clients receiving care at home.

A number of strategies have allowed people to receive care while remaining in their own homes. In improving the quality of home care services, health authorities are now providing enhanced home support services such as cluster care — a way of delivering support by assigning a single home care aide to an apartment building to meet the needs of clients throughout the day — and expanding adult day care programs, an important service to monitor people at risk, keep them engaged in their community, and allow them to remain in their homes for as long as possible. Networks of Excellence for Geriatric Services, which include community outreach, are also expanding. Specialized programs for people with brain injuries are now available to allow clients to remain in the community. Health authorities are also implementing end-of-life care strategies that include providing appropriate supports to allow people to die in their homes rather than an institution, if that is their wish.

Priority Strategy 5: Build the Foundation for Integrated Care Networks:

a) Connect physicians and other health care professionals to diagnostic services, hospitals, and each other.

b) Provide a continuum of services in each health authority for mental health and addictions patients that better integrates primary, secondary, community and tertiary care and is integrated with the larger care networks.

This strategy focuses on integrating and providing care in the most coordinated and seamless manner possible to the benefit of patients and health care providers. The first part of the strategy concerns adapting business processes and using technology to allow care providers and facilities such as laboratories and hospitals to share information and provide coordinated care. Developing an electronic health record (EHR) system is essential for electronically linking health information to support clinical and management decision-making. British Columbia continues to make good progress in this regard and is seen nationally as one of the leaders in the development of the EHR.

The second part of the strategy focuses on integrating and coordinating mental health and addiction services. In the past, people with mental illness or substance misuse disorders have generally not received the same level of care and respect as people with a physical illness. Mental illness and addictions are treatable, and with appropriate care and support, people can manage their illness better and achieve their full potential. The ministry is working with its health care partners to create networks of care in each health authority that better integrate mental health and addiction services, as well as working to provide appropriate care in patients' communities to minimize their time spent in institutions, and to improve their access to health professionals.

PS — Performance Measure 7: Improved continuity of care measured by the proportion of persons (aged 15 to 64) hospitalized for a mental health diagnosis who receive community or physician follow-up within 30 days of discharge.

This measures the percentage of persons who have been hospitalized for a mental health illness and receive at least one follow-up treatment at a community-based Mental Health Centre or with a general practitioner or psychiatrist within 30 days of being discharged from hospital. A high rate of community or physician follow-up indicates well-coordinated, accessible continuity of care for people with a mental health diagnosis.

Results

2004/05 Target	2004/05 Preliminary*	Status
Increase over prior year	2.4% increase	Achieved

	FISCAL YEAR				
	2000/01	2001/02	2002/03	2003/04	2004/05*
Annual Target	Baseline		3.0%	increase	increase
→ % Clients Followed-up	71.5%	73.0%	73.9%	74.9%	76.7%
→ Change in % followed-up from previous year		2.1%	1.2%	1.4%	2.4%
Change in % followed-up from baseline*			3.4%	4.8%	7.3%

* 2004/05 — partial year data.

DATA SOURCE: Mental Health Research Database. March 2005 Refresh (data extracted April 27, 2005). Discharge Abstract Database (DAD), December 30, 2004. Medical Services Plan fee-for-service database (MSP) payments to February 17, 2005. Integrated Mental Health Data, March 3, 2005. Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services.

NOTES: In previous reports, the historical data was held constant. In this report, all years have been updated. Changes such as a slight modification of methodology, the implementation of the Minimum Reporting Requirements (MRR) and restatement of geographical boundaries will affect the historical data.

Analysis: Based on preliminary data, the 30-day follow-up rate for the approximately 20,000 mental health and addictions clients discharged each year from hospital continues to increase, reaching 76.7 per cent in 2004/05 from the 71.5 per cent 2000/01 baseline.

Physicians and community mental health centres provide the follow-up services. The follow-up is important for the recovery and stability of patients discharged from hospitals and ensures patients are linked with appropriate community programs and resources for subsequent care, treatment and support.

Therefore, monitoring and working to increase the follow-up rate for mental health and addictions clients serves as a high-level gauge of whether the system provides integrated, supportive care.

An important facet of improving follow-up is to increase mental health services that are available in community settings and to ensure effective discharge planning processes are in place that appropriately link patients with community resources. To this end, it is positive to note the percentage of follow-up provided by community mental health centres has increased, from 18.9 per cent in 2000/01 to 36 per cent in 2004/05. On the other hand, physicians' follow-up has remained between 67 per cent and 69 per cent over the past five years.

PS — Performance Measure 8:	Improved availability of community services measured by percentage of days spent by mental health patients (aged 15 to 64) in hospital after the need for hospital care ends.

This measure indicates whether individuals with mental illness have access to timely, appropriate care in the most appropriate setting. Please note this measure is the same as the previous ALC measure (Performance Measure 3), but focuses on people who are hospitalized for a mental health diagnosis. Reducing the number of days that patients spend in hospital after their need for acute care has ended indicates that appropriate services are available in the community.

Results

2004/05 Target	2004/05 Preliminary*	Status
2% reduction over prior year	4% reduction	Achieved

	FISCAL YEAR					
	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05*
Annual Target			Baseline	0.0%	-2.0%	-2.0%
ALC Days	8,897	9,509	13,925	7,267	8,949	5,587
Inpatient Days	228,427	232,662	232,382	248,514	257,257	167,377
% ALC Days	3.9%	4.1%	6.0%	2.9%	3.5%	3.3%
→ % Change in % ALC Days from previous year	n/a	4.9%	46.6%	-51.2%	19.0%	-4.0%

* 2004/05 — partial year data.

DATA SOURCE: Discharge Abstract Database (DAD), April 7, 2005, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services.

Analysis: Based on preliminary data, the 2004/05 target for ALC rate reduction will be met.

The overall rate of ALC days for mental health and addictions diagnoses is low (less than 3.5 per cent) and the total number of individuals receiving greater than one ALC day in 2003/04 and 2004/05 comprises a very small proportion of all mental health and addictions patients in B.C.

More than three-quarters of all ALC days incurred by mental health and addictions patients in the past two fiscal years are associated with those experiencing psychotic disorders, including schizophrenia. While the total number of these patients is relatively low, they tend to consume, on average, a higher number of ALC days than other disorders.

PS — Performance Measure 9: Proportion of mental health services (community, physician and acute care) received by mental health clients (aged 15 to 64) that are obtained in their own health authority.

This indicator measures the range of services mental health and addictions clients receive in their own communities or regional health authorities. This performance measure indicates our progress in improving access and availability of mental health and addictions care and community services for individuals in their regions.

Results

2004/05 Target	2004/05 Preliminary*	Status
Increase over prior year towards long-term target of 87%	85%	Substantially Achieved

	FISCAL YEAR						
	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05*	Long-Term Target
Annual Target			Baseline	Increase	Increase	Increase	
% Services Received in Client's Own HA							
→ All Mental Health Services	85.0%	84.2%	83.6%	84.3%	85.0%	85.0%	87.0%

* 2004/05 — partial year data.

DATA SOURCE: Mental Health Research Database (MHR): March 2005 Refresh (data extracted April 5, 2005). Discharge Abstract Database (DAD), December 30, 2004. Medical Services Plan fee-for-service database (MSP) payments to February 17, 2005. Integrated Mental Health Data, March 3, 2005. Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services.

Analysis: Preliminary data for 2004/05 indicate the proportion of mental health and addictions services received in each client's regional health authority has remained stable at 85 per cent. The overall rate is made up of services provided by physicians, acute care hospitals and community mental health centers.

Core Business: Services Delivered by Partners (continued)

Goal: High Quality Patient Care (continued)

Objective 2: Provide tailored care for key segments of the population to better address their specific health care needs and improve their quality of life.

The ministry is striving to build a health system that provides patient-centred services that respond to a continuum of needs over an individual's lifetime. Most people will need a range of services:

- to help stay healthy with disease prevention and health promotion services;
- to improve health and wellness with episodic care;
- to live with illness or disability by accessing chronic disease management or care; and
- to cope with the end-of-life through hospice or palliative care.

Clearly, one size does not fit all in health service delivery. For instance, the small number of patients who currently need and use health services the most are moving in and out of the health system constantly. These patients tend to have multiple chronic and/or terminal illnesses. Evidence shows our health system does not provide these patients with optimal

seamless care and that improvements in care and outcomes can be made through innovation in our models of service delivery.

The ministry is working with health authorities and physicians to design and deliver customized care that addresses the unique needs of specific patient sub-populations. To begin, the focus is on coordinating care for patients with extensive needs, proactively managing chronic diseases, providing better care for the dying, and addressing health inequalities in B.C.'s Aboriginal population. Implementing a patient-centred approach for these populations can improve quality of life and health outcomes for patients and provide better use of health services.

Priority Strategy 6:	**Better Care for People with Extensive Care Needs: Provide integrated care and targeted services for patients who have extensive health care needs to more effectively manage their contact with health care services.**

A 2003 study showed a small percentage of B.C.'s population uses a large percentage of medical services. For instance, the data analysis showed that in hospitals, five per cent of patients account for 54 per cent of bed days and 94 per cent of days spent in hospital after the need for hospital care has ended. This data led the ministry to initiate a project to study the most frequent users of the system to find more effective ways of delivering their care. The ministry has been working with health authorities to better understand the common health concerns of this population and to develop evidence-based strategies to improve care.

Research shows other jurisdictions have improved care and reduced costs by introducing specific strategies for high needs populations. For example, providing intensive targeted care in the community to the frail elderly, such as medical, rehabilitative, social and support services, improves their health and reduces the number of hospital admissions, ambulance calls and drug claims. Other examples with similar results include improved end-of-life care and accessible community services for individuals with mental illness.

PS — Performance Measure 10:	Percentage of days spent by highest needs patients in hospitals after the need for hospital care ended, measured by alternate level of care days as a percentage of total hospital inpatient days for these patients.

The ministry has been monitoring the percentage of alternate level of care (ALC) days that high needs patients spend in hospital as an initial indicator for assessing strategies to better serve the highest needs population. For this patient group, ALC days are twice the average compared to the entire population.

This indicator is limited because a highest needs patient can only be defined after the fact — that is, the data will only capture a patient as falling in the highest needs category once that patient has received the threshold number of services to qualify. Preliminary data for 2004/05 is provided below, but given the nature of this indicator it should be noted this

data is a less reliable preliminary indication of final full year data than in other parts of this report where preliminary 2004/05 data is used.

Results

2004/05 Target	2004/05 Preliminary*	Status
5% decrease over prior year	6.7% increase	Substantially Achieved

	FISCAL YEAR					
	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05*
Annual Target				Baseline	-5.0%	-5.0%
ALC Days	347,037	374,222	352,197	311,919	278,113	182,552
Inpatient Days	1,473,586	1,484,857	1,465,555	1,441,542	1,433,675	881,639
% ALC Days	23.6%	25.2%	24.0%	21.6%	19.4%	20.7%
→ % Change in % ALC Days from previous year		7.0%	-4.6%	-10.0%	-10.3%	6.7%

* 2004/05 — partial year data.

DATA SOURCE: Discharge Abstract Database (DAD), April 7, 2005, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services.

NOTES: A slight modification in the methodology has changed the original 2002/03 baseline from 21.8% to 21.6%.

Analysis: The highest need group consists primarily of the frail elderly with multiple health problems, persons with multiple chronic medical conditions, persons with significant mental health disorders, and individuals requiring end-of-life services.

In addition to the initiatives outlined in the overall ALC measure (Performance Measure 3), health authorities have specific strategies targeting the highest needs patients. These include chronic disease collaboratives with primary care practitioners and specialists focusing on congestive heart failure, chronic obstructive pulmonary disease, depression and diabetes. Health authorities are also establishing networks of acute hospitals and health centres to optimize roles and referral relationships; enhancing end-of-life care services; expanding community mental health services; and developing self-care, health promotion and illness prevention education programs.

Substantial progress has been made. Data for 2003/04 showed a 10 per cent decrease in the proportion of ALC days over the 2002/03 baseline, continuing the downward movement in the rate since 2000/01. Partial year data for 2004/05 do not show the same decreasing trend, although it may be too early to predict year-end results. Overall, the 2004/05 partial year data still show the ALC rate for highest needs patients is 18 per cent lower than in 2000/01.

Priority Strategy 7: Better Care for People with Chronic Conditions: Increase the emphasis on the effective management of chronic diseases (e.g., diabetes) to prevent or slow disease progression.

A chronic disease is an illness that cannot be cured completely. Diabetes, depression, congestive heart failure, hepatitis C and asthma are all chronic diseases. An estimated 500,000 British Columbians suffer from one or more chronic diseases.

Effective management helps people with chronic diseases stay healthy and independent for as long as possible. The ministry is working with physicians and health authorities to help individuals maintain their health through prevention, early detection and management of chronic conditions. A number of initiatives have been implemented to ensure patients receive the highest standard of chronic disease management and care. Best practices and clinical guidelines have been developed for congestive heart failure, diabetes and other chronic diseases. In addition, in 2003, the ministry launched a two-year project called the Full Service Family Practice Incentive Program. This program aligned physician payment with quality care and provided additional remuneration for services delivered according to guidelines, and also compensated physicians for participating in quality improvement learning collaboratives. The ministry has also created chronic disease patient registries to monitor the impact of improving care, and other web-based tools to support physician practice, including a secure, web-based Chronic Disease Management Toolkit that gives authorized doctors, nurses and other care providers access to tools and information incorporating proven best practices for the treatment and management of chronic diseases.

PS — Performance Measure 11: Adherence to clinical best practices for managing chronic diseases measured by percentage of full service physicians claiming payment for treating patients according to evidence-based guidelines.

In September 2003, as part of the push to improve the treatment of chronic conditions in B.C., government introduced a $75 incentive payment per patient per year for family doctors who treat diabetes or congestive heart failure sufferers according to evidence-based, best practice guidelines. The program was the first of its kind in Canada.

Results

2004/05 Target	2004/05 Preliminary*	Status
40% of physicians claiming payment	42.1%	Achieved

	FISCAL YEAR	
	2003/04*	2004/05*
Annual Target	30.0%	40.0%
Total physicians	4,573	4,573
# Phys. claiming incentive payments	1,524	1,926
➔ % Phys. claiming incentive payments	33.3%	42.1%

* 2004/05 — partial year data (program inception on September 1, 2003, to March 31, 2004, paid to March 31, 2005).

* 2004/05 — partial year data (April 1, 2004 to March 31, 2005, paid to March 31, 2005).

DATA SOURCE: Physician Framework Supply (PFS), March 31, 2005, Information Resource Management; Medical Services Branch, Ministry of Health Services (project 2005_042cmt).

NOTES: Applicable only for patients with confirmed diagnosis of diabetes mellitus (DM) or congestive heart failure (CHF).

Analysis: When targets were originally set for this measure, because of the program's novelty, it was difficult to know how physicians would react to payments-for-conditions, guideline-based care. It is now clear the program has exceeded expectations.

Results understate true performance. Experience shows there are less actively practicing family physicians than the 4,573 with an MSP billing number. For example, many general practitioners are not involved in regular family practice but have concentrated instead on other aspects of medicine, such as providing emergency room or surgical assistant service. Only about 3,800 regularly provide office services, and quite a number of those work in walk-in-clinics rather than conventional family physician offices, which means the exact number of general practitioners who can be considered full service family physicians is almost certainly less than 3,000.

As a result, the percentage of eligible physicians claiming the incentive payment is likely over 60 per cent.

PS — Performance Measure 12: Use by physicians of appropriate drug therapies to slow or stop the progression of chronic diseases: Percentage of patients suffering from congestive heart failure who are prescribed:

a) ACE inhibitors or ARBs;

b) Beta blockers.

Over 37,000 British Columbians suffer from congestive heart failure — a chronic disease where the heart is unable to pump enough blood to meet the needs of the body's tissues. Research shows ACE inhibitor and beta blocker drugs, in combination with other treatments, significantly improve health outcomes for congestive heart failure patients; however, the rate

of prescription for these drugs does not reflect the highest standard of care. In 2004/05, the ministry and its physician partners continued broad-based work to address and overcome challenges to increasing prescription rates of ACE inhibitors and beta blockers.

Results

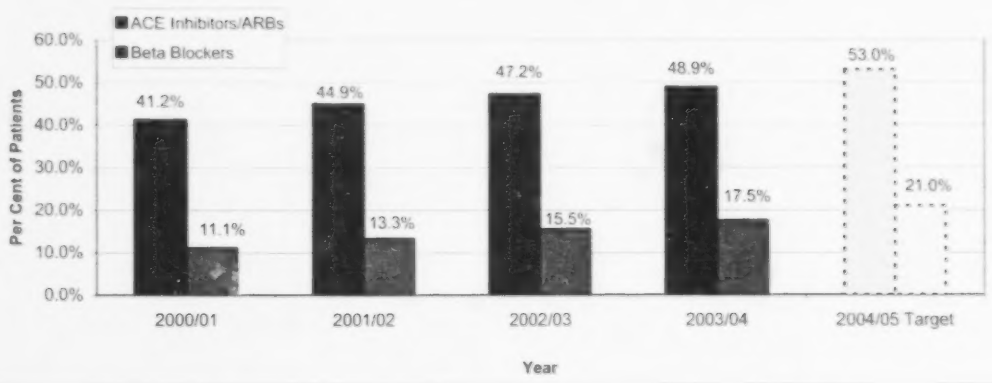
2004/05 Target	2004/05 Preliminary*	Status
a) ACE Inhibitors/ARBs 53%	N/A	Trend on track
b) Beta Blockers 21%	N/A	Trend on track

	FISCAL YEAR				
	2000/01	2001/02	2002/03	2003/04	2004/05*
ACE Inhibitors/ARBs					
Annual Target				Baseline	53.0%
% patients with CHF who are prescribed ACE Inhibitors/ARBs	41.2%	44.9%	47.2%	48.9%	n/a
Beta Blockers					
Annual Target				Baseline	21.0%
% patients with CHF who are prescribed Beta blockers	11.1%	13.3%	15.5%	17.5%	n/a

* 2004/05 — data not available.

DATA SOURCE: Physician Framework Supply (PFS), 9 Nov 04, Information Resource Management, Medical Services Branch, Medical and Pharmaceutical Services, Ministry of Health Services (project 2004_007cmt). Discharge Abstract Database (DAD), 9 Nov 04, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services. PharmaNet, 9 Nov 04, PharmaCare Branch, Medical and Pharmaceutical Services, Ministry of Health Services.

Per Cent of Patients with Congestive Heart Failure (CHF) Who Are Prescribed ACE Inhibitors/ARBs and Beta Blockers



Analysis: In the 2003/04 – 2005/06 Service Plan, the target for 2003/04 was to set a baseline and targets. This was achieved, however, the targets were found to be too high, as they did not take into account patients with diastolic heart failure, who comprise approximately half the clients with congestive heart failure. Because most published medical research has so far dealt with systolic failure, there is much less evidence on the appropriate management of diastolic failure, making treatment more uncertain. The targets have been revised to recognize these complexities.

Additionally, improvement in prescription rates for ACE inhibitors and beta blockers should be positively affected by physician uptake of the congestive heart failure incentive claim under the Full Service Family Practice Incentive Program. This program only began in September 2003, halfway through the 2003/04 fiscal year, so its full impact may not yet have been realized.

The ministry and its chronic disease management partners are working on a number of initiatives to improve care for congestive heart failure patients. For example, the ministry has organized structured collaboratives to disseminate and embed evidence-based best practice care for chronic diseases, including congestive heart failure. The collaboratives are 12-18 months long, and emphasize a team-based approach to improving outcomes. B.C.'s first congestive heart failure collaborative involved 35 general practitioners, and 820 patients. By the end of the project, 93 per cent of patients were on ACE inhibitors, and 89 per cent were on beta blockers. Currently, the Northern and Vancouver Coastal Health Authorities have embarked on congestive heart failure collaboratives, while the Vancouver Island Health Authority is midway through a three-year collaborative effort.

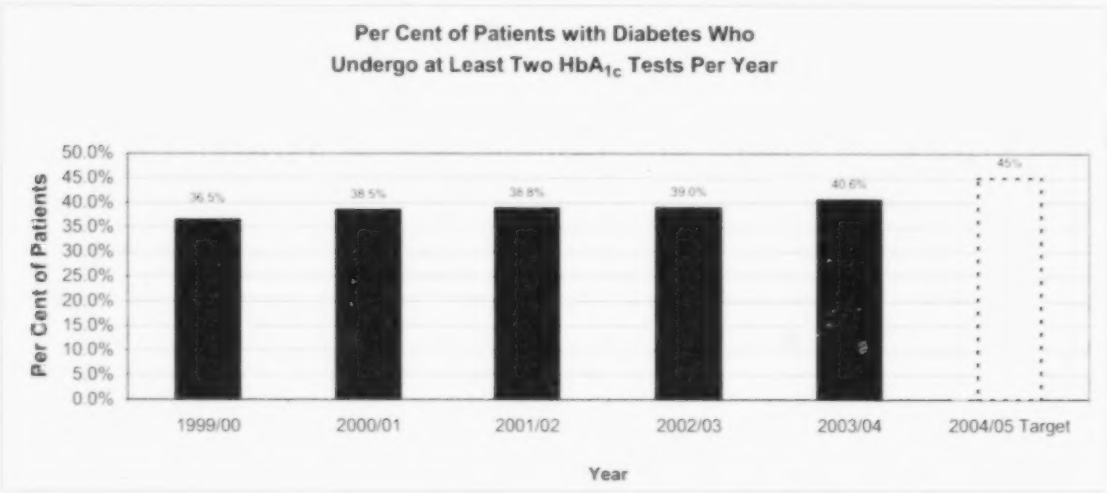
PS – Performance Measure 15:	Improve patients' ability to self-manage their chronic diseases measured by their use of evidence-based self-management techniques. For 2004/2005, we will report on the percentage of patients with diabetes who undergo at least two HbA_{1c} tests per year.

In the 2004/05 service plan, the ministry signaled its intention to track HbA_{1c} tests as an indicator of patients with diabetes being proactively involved in managing their care. With the right tools and information, patients with diabetes are aware of the importance of receiving two HbA_{1c} tests a year and are proactive in ensuring the tests are scheduled and the results discussed with their physician.

Results

2004/05 Target	2004/05 Actual	Status
45%	N/A	Trend on track

	FISCAL YEAR					
	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05*
Annual Target					40%	45%
% patients with diabetes who undergo two or more HbA_{1c} tests on different dates during the year	36.5%	38.5%	38.8%	39.0%	40.6%	n/a



* 2004/05 — data not available.

DATA SOURCE: Physician Framework Supply (PFS), 9 Nov 04, Information Resource Management; Medical Services Branch, Medical and Pharmaceutical Services, Ministry of Health Services. Discharge Abstract Database (DAD), 9 Nov 04, Information Resource Management, Knowledge Management and Technology Division, Ministry of Health Services. PharmaNet, 9 Nov 04, PharmaCare Branch, Medical and Pharmaceutical Services, Ministry of Health Services.

Analysis: Data is not yet available for 2004/05; however data for 2003/04 show the target for HbA_{1c} testing was met in that year.

2003/04 was a foundational year for chronic disease management in British Columbia. In September of that year, the Full Service Family Practice Incentive Program was introduced and for the first time a physician fee item was directly linked to providing best practice care. For diabetes, one component of this best practice care is for patients to receive two HbA_{1c} tests per year.

In 2003/04, the Chronic Disease Management (CDM) program also worked to introduce tools to assist physicians in delivering quality care. Much of the initial effort concerned establishing the necessary privacy and security practices for clinical information sharing in a

diabetes registry, and working to assist physicians through the start-up process. In 2004/05, the program expanded as health authorities were given funding to promote and support the CDM program at the local level. Cumulatively, this work has led B.C.'s CDM program to be recognized across Canada for innovation.

The ministry and its chronic disease management partners have been, and will continue to work on a number of initiatives to improve care for diabetes patients. For example, like congestive heart failure, the ministry has organized structured collaboratives to disseminate and embed evidence-based best practice care for diabetes. Diabetes collaboratives are 12-18 months long, and emphasize a team-based, patient self-management approach to improving outcomes. B.C.'s first diabetes collaborative involved 49 general practitioners, and led to 7,000 patients receiving evidence-based, clinical guideline care. By the end of the project, 54 per cent of patients were receiving HbA_{1c} tests every three months. The Vancouver Island Health Authority's three-year diabetes project is showing excellent results as well. For the 1,800 patients involved in the first wave of the project, 79 per cent received an HbA_{1c} test within the last six months.

Priority Strategy 8: Better Care for the Dying: Expand palliative care services to provide dying people with greater choice and access to services.

Palliative care is the specialized care of people who are dying; it is an integral part of a health system that meets the needs of people across their lifespan. Good palliative care is provided, where possible, in the setting of a person's choice and is delivered by coordinated teams of physicians, nurses and other health professionals such as pharmacists and nutritionists, and includes family input and volunteer services.

The ministry has worked with partners, including health authorities, physicians and the B.C. Hospice Palliative Care Association, to enhance and coordinate palliative services across the province. In B.C., publicly funded palliative care includes care provided in palliative care units or hospices in hospitals, as well as care provided in a person's home or other community-based setting. To promote innovative palliative care services, the ministry introduced the Palliative Benefits Program, which provides medications, medical supplies and equipment to those who choose to die at home. Previously, those items were only covered if the patient stayed in hospital. The Palliative Benefits Program is an important resource that allows health authorities and care providers to design programs to support people who choose to die at home or in settings outside the hospital.

PS — Performance Measure 13: Percentage of patients in B.C. accessing the home-based PharmaCare Palliative Plan in the 12 months prior to death.

As first noted in the 2003/04 service plan, the ministry has been monitoring and reporting the percentage of people accessing benefits under the Palliative Benefits Program as an interim measure of availability of end-of-life care services. Although this measure only captures one component of palliative services, it does indicate broader access to palliative

care based on the assumption that clients who access the benefits program are likely accessing other palliative services, such as physician, home nursing or hospice care.

In the future, this indicator will be replaced with a more specific measure of access to palliative care. The development of a new measure is discussed in the analysis below.

Results

2004/05 Target	2004/05 Preliminary*	Status
15%	14.8%	Substantially Achieved

		FISCAL YEAR			
		2001/02	2002/03	2003/04	2004/05*
	Annual Target		Baseline	13.0%	15.0%
	Deaths in fiscal year	28,864	28,910	29,684	28,480
	# deaths with at least 1 prescription under Palliative Care Benefit Program	3,447	4,226	4,676	4,228
→	% deaths with at least 1 prescription under Palliative Care Benefit Program	11.9%	14.6%	15.8%	14.8%

* 2004/05 — partial year data (April 1, 2004 to March 15, 2005).

DATA SOURCE: HNData, Policy Development and Management, PharmaCare. Death Records, Vital Statistics Agency, Ministry of Health Services.

Analysis: Drug benefits under B.C.'s Palliative Care Benefits Program have been available since 2001. Plan P uptake has increased since its inception as familiarity with the program has grown, and clients choose home as the setting for end-of-life care. The continued enhancement of palliative care, and especially community-based services, will likely lead to further increase in the use of these benefits.

As signaled in the previous annual report, for the 2005/06 service plan the interim Plan P measure has been replaced by a more comprehensive measure of palliative care services: *the percentage of natural deaths occurring in hospital*. Currently 56 per cent of natural deaths occur in hospital. The ministry has identified a long-term target to reduce it to 40 per cent by expanding community, home, and hospice care services for end-of-life, while still respecting those who prefer to die in a hospital setting.

Priority Strategy 9: Improve the Health Status of Aboriginal Peoples: Support initiatives to improve Aboriginal health through the formalized participation of Aboriginal people in the planning and delivery of health care.

Improving the health status of Aboriginal peoples is a priority of government. While significant improvements have been made with respect to the health status of Aboriginal

peoples in recent times, the overall health status of the Aboriginal population continues to remain below that of the general population.

The ministry and health authorities are pursuing a number of strategies to improve Aboriginal health. Health authorities are developing and implementing regional Aboriginal health plans, administering targeted regional funding through the Aboriginal Health Initiatives Program, and ensuring coordination and integration of Aboriginal health services into the overall planning and delivery of health programs within the province.

The ministry is also working with stakeholders throughout the province to reduce the incidence and complications of various illnesses. An example is the National Diabetes Surveillance System project, aimed at reducing the incidence and complications of diabetes through leadership in the development, implementation, and national coordination of provincial, territorial, and Aboriginal diabetes surveillance systems. Other priority strategies to improve Aboriginal peoples wellness include targeted actions to reduce smoking rates, deaths due to injuries and preventable hospital admissions, and to improve Aboriginal participation in preventive health strategies such as immunization, mammography and pap smear screenings.

PS — Performance Measure 14: Improved health status for Aboriginal peoples measured by:

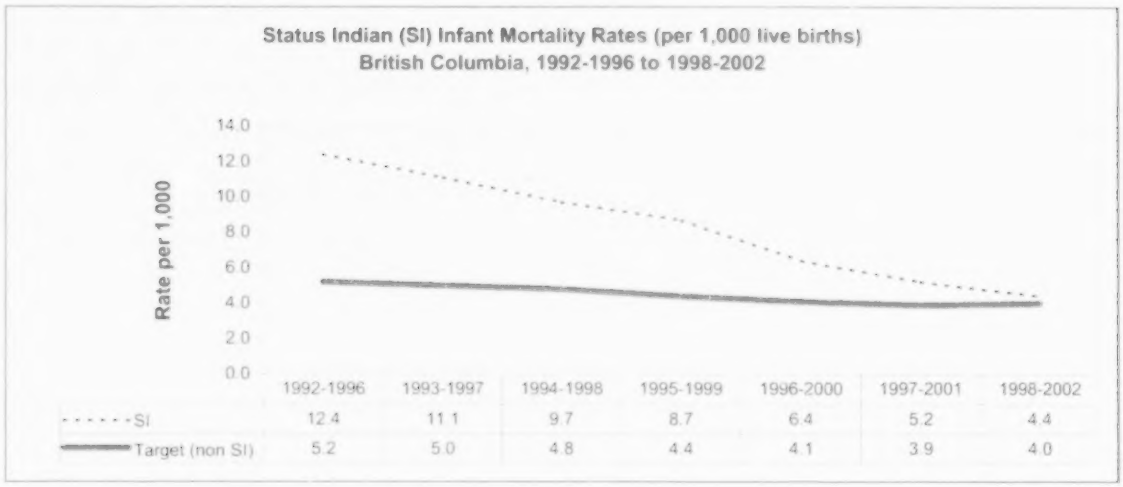
a) infant mortality, and

b) life expectancy.

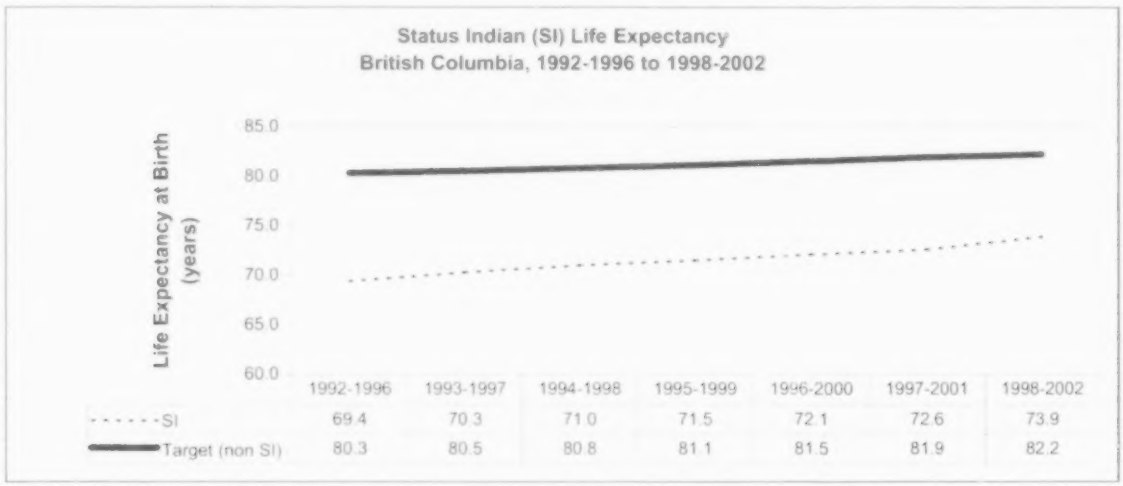
The Ministry of Health Services tracks infant mortality rates and life expectancy because they serve as useful indicators of the overall health status of Aboriginal people. Data for 2003 are not available at the time of publication; however, data for the past decade is presented and provides useful insight for trends in Aboriginal health status.

Results

2003 Target	2003 Actual	Status
a) No statistically significant difference in infant mortality rates between Status Indians and other residents of B.C.	N/A	Trend on track
b) 1999-2003 Status Indian life expectancy of 74.2 years.	N/A	Trend on track



Analysis: Since 1990 in B.C., the infant mortality rate for the Aboriginal Status Indian population declined from a high of 15.6 per 1,000 live births in 1992 to a low of 4.0 in 2000. Over the past decade, the gap between infant mortality rates in the Aboriginal population and the total B.C. population has decreased to being statistically insignificant. This is a vast improvement over the mid-1990's when the Aboriginal rate was over double the provincial rate.



DATA SOURCE: BC Vital Statistics Agency, Knowledge Management and Technology Division, Ministry of Health Service.

NOTES: Status Indians births are defined as those births where either the mother or father is Status Indian. The registration of Status can take several years, thus confirmation of official registration is not required in the Vital Statistics records.

Analysis: For British Columbians, life expectancy (five-year average) since 1986 has increased steadily from 80.3 to 82.2 years in the general population, and from 69.4 to 73.9 years in the Status Indian population. Although still less, Status Indian life expectancy

is growing faster than for other residents of B.C., so the gap is gradually closing in both absolute and relative terms. This positive trend is expected to continue.

Core Business: Services Delivered by Partners (continued)

Goal: Improved Health and Wellness for British Columbians

Objective 3: Keep people as healthy as possible by preventing disease, illness and disability, and slowing the progression of chronic illness to minimize suffering and reduce care costs in the future.

While British Columbians in general are among the healthiest people in the world, certain segments of the population do not share that status. Many citizens are still at risk from factors such as poor dietary habits, obesity, inactivity, accidents and tobacco use. In addition to poor health, the consequence of preventable illness is that vast resources are spent "after the fact" — once a disease or injury has occurred.

In these cases, an ounce of prevention is worth a pound of cure. Services such as public health protection, illness and injury prevention, and chronic disease management are important for maintaining and improving health outcomes, while containing overall health system costs. If we can support British Columbians' efforts to stay healthy and out of the health system, we win on two fronts: people achieve better health, and scarce resources can be used to provide appropriate care for non preventable illness.

The ministry and its health care partners have used two main approaches for keeping people healthy. The first is to provide health information and resources to support people to manage their health and reduce the burden of disease, injury and disability. The second is to provide effective public health services to prevent illness and disability. These include immunization programs, infectious disease prevention and control, and monitoring and regulating water, food and environmental safety.

Priority Strategy 10: Enhancing Self-Care and Self-Management: Support individuals' self-management efforts to help healthy people stay healthy and allow people with chronic conditions to better manage their condition.

Staying healthy or caring for a chronic disease, injury or illness does not begin or end at the doctor's office. In order to stay healthy, or manage diseases like congestive heart failure and diabetes, patients must also participate and take responsibility for their own care. By monitoring their health, improving their diet and getting exercise, patients get the best care possible.

In 2004/05, government launched ActNow BC, the most comprehensive health promotion program of its kind in North America. ActNow BC is a program to promote healthy lifestyles and prevent disease by providing people with the information, resources and support they

need to make healthy lifestyle decisions. Specifically, ActNow BC is focused on improving health by promoting physical activity, healthy eating, living tobacco free, and making healthy choices during pregnancy.

Performance Measures: In the 2004/05 service plan, the ministry signaled its intention to track HbA_{1c} tests as an indicator of patient self-management. This measure is a good indicator of patients being involved in and receiving quality care for a chronic condition (diabetes), but is not a strong measure of the population's overall health. Accordingly, results for the HbA_{1c} measure are reported under the chronic disease management section of this report (see Priority Strategy 7).

Developing performance measures for increases in physical activity and self-management of health conditions is difficult. Ultimately, the best indicators are improvements in health status and outcomes, which are measured over long periods of time. These indicators can be found in the Provincial Health Officer's Annual Reports, available on the ministry's website http://www.healthservices.gov.bc.ca/pho/ar/index.html *.

The ministry, in its 2005/06 – 2007/08 Service Plan, has committed to monitoring and reporting smoking rates and obesity rates as key measures of the impact of ministry and government programs to promote healthy living.

Priority Strategy 11:	**Protection from Disease or Injury: Protect public health by implementing core public health prevention and protection programs (e.g., food and water safety programs, immunization programs, falls).**

Government plays an important role in monitoring population health and protecting public health. Legislation and regulation of food, air and water quality lays the foundation for communities and citizens to live in healthy and safe environments. Programs that target and prevent certain diseases, like influenza, also contribute to maintaining and improving the health of British Columbians.

In May 2003, the ministry brought into force the new *Drinking Water Protection Act*. Under the Act, government has dedicated additional resources to drinking water and water source protection to enhance the quality of drinking water in British Columbia. Also, in July 2004 government modernized its Meat Inspection Regulation as part of ongoing improvements to the 2002 *Food Safety Act*. The new regulation harmonizes its protocols with the National Meat Code, and provides province wide standards for the construction and operation of slaughtering facilities, including a provision that animals raised for sale require mandatory inspection before and after slaughter.

PS — Performance Measure 16: Immunization rates.

a) Two-year-olds with up-to-date immunizations.

b) Influenza immunization for residents of care facilities.

* *Refer to note on page 3.*

a) Immunization rates for two-year-olds: Immunization programs for children are among the most cost-effective ways to improve population health, prevent illness, and reduce health care costs. In B.C., all infants and preschool children have access to immunizations that protect them from the following diseases: diphtheria, pertussis, tetanus, polio, *haemophilus influenza* type b, measles, mumps, rubella, and hepatitis B. In 2003, B.C. introduced the meningococcal C conjugate and pneumococcal conjugate vaccine programs. In January 2005, B.C. introduced an infant varicella (chickenpox) program. These new programs are not yet included in the data results.

Results

2004/05 Target	2004/05 Actual	Status
85%	69.2%	Not Achieved

	CALENDAR YEAR
	2004
Target	85.0%
Up to date for age	69.2%
→ Up to date except booster	88.4%

DATA SOURCE: Public Health Information System (iPHIS), January 31, 2005, British Columbia Centre for Disease Control (BCCDC)

NOTES: Please note that this data is not comparable with the 2 year old April cohort immunization data reported prior to 2004.

Data need to be interpreted with caution for the following reasons:

1. There are differing practices across regions and in some cases between the Health Service Delivery Areas within the three regions for activating or inactivating records of children for immunizations.
2. Some regions have their physicians reporting immunization and other regions do not. There is also a delay in obtaining these records from physicians, which can result in delay of data entry. This will artificially lower the rates of vaccine coverage.
3. Anecdotally, the practice in some regions for children who are delayed on their 6 month dose of vaccines is to defer receipt of the 4th dose until at least 12 months after the third. This can result in lower up to date for age rates at the 2nd birthday.
4. Data completeness with respect to children residing in the Health Authority — some regions enter all children born in their region into iPHIS. Other regions enter only those children into the system that present for service. This will lead to an incomplete registry system. It is our opinion based on the difference found in the 2001 cohort of children followed up in the MSP study that these numbers represent the limitations in the data population of our registry system.

Analysis: In 2004, BC Centre for Disease Control (BCCDC) assumed responsibility for the analysis and reporting of immunization data. Previously, the ministry had collected data directly from health authorities. Shifting responsibility to the BCCDC has strengthened the data quality and better aligned the process with other public health data activities. A side effect of this change, however, is that 2004 annual data are not comparable to the data reported in 2003.

The 2004 data show that the B.C. rate of complete immunization for two-year-olds at 69.2 per cent, short of the ministry's target of 85 per cent. However, the data also indicate that 88.4 per cent of two-year-olds have received all of their shots except for the booster shot given at 18 months of age. This is encouraging, as it indicates most infants are getting the

majority of their early shots. The ministry, BCCDC and health authorities are now working to have a higher percentage of infants receive the 18-month booster shot.

Moving forward, BCCDC will also work with all health authorities to further standardize and improve data quality.

b) Influenza immunization for residents of care facilities.

Results

2004/05 Target	2004/05 Actual	Status
Maintain at 85% (or higher)	91.8%	Achieved

DATA SOURCE: Data are submitted by Health Authorities (Annual Influenza Immunization Program Survey). 1999/2000 to 2002/03 — compiled by Population Health and Wellness Division, BC Ministry of Health Services. 2003/04 onward — compiled by Epidemiology Services, BC Centre for Disease Control

NOTES: Resident influenza vaccine coverage was unreported for 31.6% of long term care facilities in British Columbia.

Analysis: Data for 2004/05 influenza immunizations for residents of care facilities show an increase from 89.7 per cent in 2003/04, to 91.8 per cent, well in excess of the target rate of 85 per cent.

Importantly, this year's data comprises a higher percentage of care facilities across B.C. Last year, data covered 59.4 per cent of facilities. This year, the number of facilities reporting increased in every health authority, to an overall B.C. rate of 68.4 per cent. BCCDC continues to work with health authorities to improve the data quality.

Core Business: Services Delivered by Partners (continued)

Goal: A Sustainable, Affordable Health Care System

Objective 4: Manage within the available budget while meeting the priority needs of the population.

The ministry is committed to working with its partners to manage the health system efficiently to ensure resources are spent where they will have the best outcome. This objective, however, is about more than just keeping costs down — it is also about managing the system in such a way that services are provided effectively and in a high quality manner. With the move to six health authorities, a more streamlined, cost-efficient and accountable governance structure is in place, allowing more resources to flow directly to patient care. In delivering the full continuum of care to local residents, regional health authorities now have the flexibility to make decisions about what programs and services best meet the needs of local people. The result is more responsive and more accountable service.

Priority Strategy 12: Service Quality Enhancement: Ensure clinical services are organized and delivered safely, cost-effectively and at a high quality.

Each health authority has been working to create networks of health and community services to provide quality, coordinated care. For example, by linking small community hospitals with basic emergency services to larger community and regional hospitals with more complex care capabilities, health authorities are able to provide high quality care and more timely access to multiple levels of service. A coordinated, integrated health system also improves accessibility to physician services, recruitment and retention of family physicians and specialists, and health outcomes for patients.

It is also important that clinical services are organized safely, cost-effectively and at a high quality. Almost all types of medical treatment come with some risk of harm. This is obvious in the case, for example, of surgery or radiation therapy, but it also applies to drugs, many diagnostic tests and other types of treatment. Accordingly, the ministry, health authorities and health professionals have been working together on patient safety initiatives.

PS — Performance Measure 17: Develop patient safety programs and performance measures.

Progress: The Patient Safety Task Force (PSTF), a group composed of Vice Presidents of Medicine, Chief Nursing Officers and representatives of the ministry and the Health Care Protection program, was formally inaugurated on May 7, 2004. The PSTF brings together clinical leaders to work on improving patient safety in areas from drug reactions to hospital-acquired infections.

Among other achievements, the PSTF is facilitating a baseline medication safety survey in 50 B.C. hospitals under the Institute for Safe Medication Practices Canada. It has also adopted and disseminated patient safety goals to guide hospital safety improvement, and is leading B.C.'s response to the Canadian Adverse Events Study: *The Incidence of Adverse Events in Hospitalized Patients in Canada*.

In addition, the ministry has made a one-time investment of $3 million to establish a research chair of patient safety at UBC's faculty of medicine.

Priority Strategy 13: Managing within Budget Allocation: Manage the delivery of services within budget.

When the new governance model for B.C.'s health system and six health authorities was created in 2002, the government made it clear these new authorities would be expected to manage health care in their regions within their budgets. In 2004/05, health authorities became part of the Government Reporting Entity (GRE) and as such are subject to many of the same reporting, budgeting and financial requirements as the rest of government. In accordance with the *Balanced Budget and Ministerial Accountability Act*, government had

to balance the budget in 2004/05, including the operating results of all entities within the GRE. Accordingly, health authorities are expected to balance their budgets each year.

PS — Performance Measure 18: Spending on administrative and support services by health authorities.

This indicator measures the amount health authorities spend on administrative and support services compared to their total expenditures. Administrative services include finance services, human resources and communications. Support services include maintenance, housekeeping, food services and security. To ensure maximum resources are directed to patient care, in 2002/03 health authorities were given a three-year target of reducing administrative and support services by seven per cent by the end of 2004/05 (compared to 2001/02 levels).

Results

2004/05 Target	2004/05 Preliminary	Status
At least a 7% reduction in annual expenditures for administrative and support services (excluding Information Systems) from 2001/02 baseline.	All health authorities have achieved at least a 7% reduction.	Achieved

Analysis: Audited financial statements are not available at the time of publication, however preliminary results indicate each health authority has reached the seven per cent reduction target by the end of the 2004/05 fiscal year.

PS — Performance Measure 19: Health authorities in a balanced budget position each fiscal year.

Results

2004/05 Target	2004/05 Actual	Status
Balanced budget for each health authority.	All health authorities have balanced budgets for 2004/05 fiscal year.	Achieved

Analysis: Audited financial statements are not available at the time of publication, but preliminary results indicate that health authorities have achieved balanced budgets for the 2004/05 fiscal year.

Core Business: Services Delivered By Ministry

While the vast majority of health services are delivered in partnership with health authorities, physicians and other care providers, the ministry does deliver some services directly to the public.

Goal: High Quality Patient Care

Goal: A Sustainable, Affordable Health Care System

Objective 5: Provide clients with equitable and timely access to services directly delivered by the ministry.

This objective focuses on improving the services the ministry currently delivers directly to the public. Priorities include better integration of ambulance services with other health services, and timely delivery of Medical Service Plan (MSP) and PharmaCare registration services and Vital Statistics services. The ministry has worked to develop new models for delivering these customer services efficiently and effectively, while making the health system affordable.

Priority Strategy 14:	**Better Integrate the B.C. Ambulance Service within the Overall Health Services System: Review the ambulance service to ensure it is governed, managed and delivered by the most appropriate means and most appropriate providers to meet the needs of British Columbians.**

The B.C. Ambulance Service is a key part of the health care system, providing pre-hospital treatment and transportation. The ambulance service operates 190 ambulance stations across the province and employs approximately 1,250 full-time and 2,000 part-time paramedic and dispatch staff.

The ministry is committed to ensuring the ambulance service delivers responsive and efficient care, and that the service is flexible and financially sustainable to meet the needs of B.C. patients now and in the future. To meet this commitment, the ministry is working to better integrate ambulance services with health authorities, to strengthen coordination of pre-hospital emergency care, and to better manage inter-facility transfers.

In 2004/05, the B.C. Ambulance Service reached a new framework agreement with government. It provides for enhanced training opportunities for paramedics, better service coverage for rural areas, and increased access to Advance Life Support trained paramedics for metropolitan areas.

PS — Performance Measure 20: Ambulance service response rates.

This measure provides insight as to whether the ambulance service is performing its principal responsibility well — responding to sudden, acute care needs as quickly as

possible. Many metropolitan Emergency Medical Services in Canada have adopted a response time goal of less than nine minutes, 90 per cent of the time. Although ideal to strive towards, meeting this goal in all communities can be difficult given the variances in geographic size and population density among communities.

Results

2004/05 Target	2004/05 Actual	Status
5% increase over prior year toward long-term target (9 minutes, 90% of the time).	7.4% increase	Achieved

	FISCAL YEAR			
	2001/02	2002/03	2003/04	2004/05
Target		5.0%	5.0%	5.0%
Total # urgent calls in metropolitan settings	19,899	22,337	23,814	27,310
# Responses within 9 minutes	8,689	11,509	13,099	16,310
% Responses within 9 minutes	53.8%	57.5%	64.5%	69.3%
→ % Change in % responses within 9 minutes	—	6.8%	12.2%	7.4%

DATA SOURCE: 2001/02 — Management Information System (MIS), BC Ambulance Service, Ministry of Health Services 2002/03 onward — DataMart (derived from CAD), BC Ambulance Service, Ministry of Health Services.

Analysis: There are essentially two factors to meeting the nine-minute response time standard:

1) Efficiency — which is the sum of the time it takes to assess a call for help (dispatch time), and for an ambulance crew to respond to the scene of the incident;

2) Availability — whether a unit is available to respond to the incident (unit utilization and deployment).

Preliminary data show the ambulance service continues to improve response time performance. Like the previous year, most improvements resulted from greater efficiency. In Vancouver, for example, the rollout of a Computer Assisted Dispatch system has improved mapping knowledge, automatically identifying locations of callers and electronically signaling an ambulance crew dispatch for an emergency even while information is being collected.

Improving the availability element of response time is more complex, and is affected by the number of ambulances, the geographic location of stations, and the time units spend in hospital. BCAS is working with health authorities to reduce the amount of time paramedics get tied up at emergency rooms waiting for their patients to be admitted.

Priority Strategy 15: Improve Registration Services to the Public: Review the MSP and PharmaCare registration criteria and processes to ensure they provide appropriate and timely services to British Columbians and are managed and delivered by the most appropriate and efficient means.

The Medical Services Plan (MSP) provides coverage to beneficiaries for medically required services provided by physicians and some other health care practitioners. PharmaCare is the province's drug insurance program, which helps British Columbians by providing financial assistance toward eligible prescription drugs and medical supplies. In 2004/05, the ministry administered the two programs, including registering B.C. residents who are eligible for coverage. The ministry was committed to improving registration services, and successfully negotiated an alternative service delivery arrangement with a private sector partner. On April 1, 2005, Maximus BC began a ten-year contract to provide the administrative functions of these programs. The new program is called Health Insurance BC (http://www.hibc.gov.bc.ca*).

PS — Performance Measure 21: Percentage of the population adequately insured against catastrophic prescription drug costs.

British Columbia provides one of the best prescription drug coverage programs in Canada. Through the PharmaCare program, British Columbians are insured against catastrophic drug costs. The Fair PharmaCare Plan is the main benefit plan offered by the program. The plan focuses financial assistance on B.C. families who need it most. Started in May 2003, Fair PharmaCare combined the previous major PharmaCare plans — the universal plan and the seniors' plan — into one, with assistance based on families' ability to pay. To receive their maximum level of financial assistance, individuals or families are required to register with the Fair PharmaCare Plan. B.C. families with the lowest incomes will receive immediate financial assistance under the plan, while other B.C. families will pay their full prescription drug costs until they reach their deductible. Once their deductible is reached, PharmaCare will assist families in paying for their eligible drug costs for the remainder of the year.

Results

2004/05 Target	2004/05 Actual	Status
73% of the population registered for Fair PharmaCare.	69.3%	Substantially Achieved

DATA SOURCE: Registration Database, March 21, 2005, Fair PharmaCare, Ministry of Health Services eCorrespondence, Program Management, MSP Operations, Ministry of Health Service.

Analysis: Fair PharmaCare registration reached 69.3 per cent in 2004/05. In addition to Fair Pharmacare Plan registrations, another 160,000-plus low-income individuals in British Columbia received prescription drug coverage as clients of the Ministry of Human Resources. It should be noted that less than half of families registered under Fair

* *Refer to note on page 3.*

PharmaCare make a claim to the plan. Therefore, government does not expect significant increases in registration from the current level, as it is likely those British Columbians who require benefits from the Fair Pharmacare Plan are already registered.

PS — Performance Measure 22:	Turnaround times for MSP beneficiary services to the public: a) Enrolment applications. b) Premium assistance applications.

Measuring the amount of time it takes for applications and premium assistance applications to be processed are key indicators of MSP/PharmaCare registration services. Enrolment applications are used for new or returning beneficiaries, while premium assistance applications are for beneficiaries whose income level makes them eligible for reduced premium payments.

Results

2004/05 Target	2004/05 Actual	Status
a) 6 week turnaround time.	a) 6 weeks	a) Achieved
b) 4 week turnaround time.	b) 4 weeks	b) Achieved

		2002/03	2003/04	2004/05
Enrolment Applications	Target	Baseline	8.0	6.0
Average turnaround rate (weeks)	Actual	16.0	4.5	6.0
Premium Assistance Applications	Target	Baseline	6.0	4.0
Average turnaround rate (weeks)	Actual	12.0	5.5	4.0

DATA SOURCE: eCorrespondence, March 31, 2005, Program Management, MSP Operations, Ministry of Health Service.

Analysis: Prior to entering into a contract with Maximus BC to provide administrative services for the Medical Services Plan, the ministry made significant efforts to reduce processing times and inventory volume for enrolment and premium assistance applications.

For MSP beneficiary enrollment applications, turnaround time fell 64 per cent from 2002/03. Also, total inventory volumes (backlog) dropped from 20,837 applications in April 2003 to 10,062 in March 2005, while over the same period, inventory more than 60 days old fell from 64 per cent to 11 per cent.

For MSP premium assistance applications, turnaround time fell 66 per cent from 2002/03. Also, total inventory volumes dropped from 17,266 applications in April 2003 to 6,704 by March 2005, while over the same period, inventory more than 60 days old fell from 55 per cent to three per cent.

The ministry's contract with Maximus BC to deliver these services will ensure the capacity is maintained to support or improve on these service levels.

Priority Strategy 16: Provide Timely, High-Quality Vital Statistics Services to the Public.

The British Columbia Vital Statistics Agency is responsible for documenting important events for B.C. citizens such as births, marriages and deaths. The Agency has pursued a number of strategies to ensure it provides timely and efficient services. Most notably, it has piloted an electronic service for the registration of births and deaths; maintained customer satisfaction levels while implementing nationally mandated identification security measures; and improved direct electronic access to users of vital event health-related information products from the VISTA data warehouse to support health planning and surveillance activities.

Performance Measure 23: Vital statistics registration turnaround times.

Results

2004/05 Target	2004/05 Results	Status
35 days from date of event to complete registration for 90% of events reported.	34 days	Achieved

DATA SOURCE: The Vital Statistics registry system (VISION), April 29, 2005, British Columbia Vital Statistics Agency, Knowledge Management and Technology Division, Ministry of Health Services.

Analysis: The Vital Statistics Agency surpassed its 2004/05 target by completing 90 per cent of the registrations of birth, death, and marriage events in 34 days. The agency will continue to explore strategies for further reduction of registration processing times. Reducing the time between the occurrence and report of vital events will enhance the timeliness of the data collected, thereby making it more valuable to health researchers and planners.

PS — Performance Measure 24: Customer satisfaction rates (courtesy, helpfulness, promptness).

Results

2004/05 Target	2004/05 Results	Status
96% of customer satisfaction responses are satisfactory or better.	97.5%	Achieved

DATA SOURCE: BCVSA Customer Satisfaction Survey, April 29, 2005, British Columbia Vital Statistics Agency, Knowledge Management and Technology Division, BC Ministry of Health Service.

Analysis: The Agency achieved a 97.5 per cent rating for customer satisfaction in areas of courtesy, helpfulness, and promptness. This high rating from customers was achieved even though the Agency has been implementing new security-related initiatives that could have

negatively affected customer satisfaction. However, the Agency has managed to maintain high satisfaction levels during the implementation period, and will strive continue to do so as additional security measures are developed and implemented over the next several years.

PS — Performance Measure 25: Expand scope of clients having access to Vital Statistics VISTA data warehouse.

Results

2004/05 Target	2004/05 Results	Status
Electronic access to VISTA provided to Medical Health Officers, health authorities, and primary users at other ministries.	Medical Health Officers, health authorities, Chief Coroner's Office, BCCDC, and MCFD given appropriate access	Achieved

Analysis: Access to the Vital Statistics data warehouse (VISTA) enables in-depth analyses of mortality and natality health issues to support health surveillance, program planning and monitoring, resource allocation, and health research by individuals and organizations engaged in these activities. In 2004/05, secure access to VISTA was expanded to include all provincial Medical Health Officers, health authorities, staff at the Ministry of Children and Family Development, the Chief Coroner's office, and the BC Centre for Disease Control.

Core Business: Stewardship

Goal: Improved Health and Wellness for British Columbians

Goal: High Quality Patient Care

As steward of the health system, the ministry provides leadership and support to health authorities and other partners in delivering quality health services to the public. The ministry's stewardship objectives and strategies are designed to assist our service delivery partners fulfill the objectives and strategies listed in the previous section, and ensure the health system operates in accordance with government's strategic direction. Stewardship strategies are organized under three objectives, which represent the main components of effective stewardship: Strategic Direction, Support to Partners, and Monitoring, Evaluation and Course Correction.

Each stewardship objective contributes to all three goals of the ministry. That is, effective stewardship by the ministry will contribute to a system with improved health and wellness for British Columbians, and high quality patient care that is sustainable and affordable.

Unlike the previous sections of this report, most performance measures in this section are qualitative. Therefore, performance reporting is primarily based on detailing the ministry's progress in implementing its stewardship strategies.

Objective 1: Direction — Government's strategic direction is clearly defined and communicated and guides service delivery.

The ministry is committed to leading and fostering a culture in which health system activities are evidence-based, well planned and understood, and in which accountability structures exist to ensure strategic directions guide service delivery activities. The ministry's strategic direction for the health system must be well articulated and communicated to the public and to those who deliver services to the public.

The ministry has undertaken several strategies to meet the objective of providing clear strategic direction for the health system. The following pages outline each of the strategies and report on the progress to date in meeting the performance expectations in the 2004/05 – 2006/07 Service Plan.

MOHS Strategy 1: Translate health care needs into clear strategic direction and measurable expectations that will guide operational management and delivery of health services.

To be effective the health system needs to be planned, well managed, responsive to patient and public needs and accountable to the public. We need to focus on the changing and diverse needs of British Columbians, and develop short and long term strategies to ensure those needs are met. Those strategies must then be communicated and well understood by

all stakeholders in the system, and accountability measures must be in place to ensure the delivery of services meets patient needs.

MOHS — Performance Measure 1:	Mid- and long-term direction setting plans for the health sector completed.

Target 2004/05: Health system directional plans published; implementation of strategies in progress.

Rationale: The health system is multi-faceted and complex. Planning for a social program as large as the health system occurs on many levels, in many places, and involves numerous health care partners, stakeholders and organizations. To ensure all components of the system are working toward the same goals, the ministry is developing an overall directional plan. The plan will detail the major strategies government will pursue to sustain and improve the publicly funded health system.

Progress: The ministry has substantially completed a long-term directional plan that includes a planning framework, the system shifts required to achieve government's health system goals, and the strategic investments needed to support these shifts. The draft framework was used to develop the ministry's 2005/06 – 2007/08 service plan. The full Directional Plan and supporting materials are expected to be released in Fall 2005.

MOHS — Performance Measure 2:	Health authorities' ratings of the clarity, timeliness and usefulness of government direction in guiding service delivery.

Target 04/05: Implement surveys and determine baseline data.

Rationale: As the ministry strives to provide clear and timely direction to those who deliver health services, it is also important to receive feedback from the recipients of that direction. Working together will help identify strengths and gaps, and inform our efforts to clarify and improve our strategic direction and communication with our service delivery partners. To begin, we are developing and implementing a survey seeking the opinions of senior health authority personnel. This assessment tool will provide a comparable, clear measure of the ministry's performance over time.

Progress: The ministry is nearing completion of the survey tool with implementation of the survey scheduled for Fall 2005.

MOHS Strategy 2:	**Facilitate the delivery of health services by partners through the development and use of best practice guidelines, standards and protocols.**

Effective stewardship requires that the ministry not only provide strategic direction through broad planning, but also operational support through the research of best practices in service delivery. Scanning other health systems for best practices and incorporating them in B.C. can improve patient care and outcomes. The ministry works with professional groups, such as

physicians and other health professionals, to research and develop best-practice guidelines, standards and protocols for use across the system.

MOHS — Performance Measure 3:	Strategic clinical practice guidelines/standards in priority areas developed and implemented.

Target 2004/05: Develop guidelines for rheumatoid arthritis and chronic obstructive lung disease.

Rationale: Best practice guidelines are an important and growing component of providing quality care. By researching the best outcomes and methods of delivering care across the world, and implementing those practices in B.C., we can help ensure B.C.'s patients are getting the best possible care. In B.C., guidelines and protocols are developed jointly under the direction of the Guidelines and Protocols Advisory Committee (GPAC), jointly sponsored by the B.C. Medical Association and the ministry.

Progress: The chronic obstructive pulmonary disease guideline was approved, and the rheumatoid arthritis guideline is at the approval stage. In all, 16 guidelines were developed in 2004, including diagnosis and management of major depressive disorder, investigation and management of iron deficiency and clinical management of chronic hepatitis B and C.

MOHS Strategy 3:	**Protect public health by articulating expectations for core public health prevention and protection activities, including standards for their delivery.**

The goal of public health programs and initiatives is to protect health and prevent disease, injury, premature death and disability, and improve population health. Public health functions encompass programs in four areas — health improvement, prevention of disease, disability and injury, environmental health and emergency health management — delivered using the public health strategies of health promotion, health protection, preventive services, assessment of population health and surveillance of disease.

MOHS — Performance Measure 4:	Priority programs developed for prevention and protection.

Target 2004/05: Development of accountability framework completed to ensure health authorities meet core program requirements.

Rationale: The ministry is working with health authorities to develop a set of public health core functions. These will include mandatory, legislated, long-term programs representing the minimum level of public health services that health authorities will be required to provide to their regions and communities. Each program will have clear goals, measurable objectives and an evidentiary base that illustrates effectiveness in protecting and improving people's health and preventing disease, disability and/or injury. The programs will also be supported through identification of best practices and national and international benchmarks. The identification and implementation of public health core functions will

help ensure public health capacity within the health authorities remains focused on the most critical areas (i.e., those areas of public health with the greatest potential for positive impact).

Progress: The ministry has distributed an overview document entitled, *Public Health Renewal: Core Functions,* to health authorities. This is a companion document to the more detailed resource document, *Core Functions in Public Health*, which will be distributed in the near future. Additionally, a joint health authority and ministry Performance Improvement Process Steering Committee has been created to define the scope of the performance improvement process, and to oversee the development of performance measures by a series of working groups.

MOHS Strategy 4: Enhance the quality and accountability of self-regulated health care professionals in British Columbia by developing a regulatory framework to support and guide their work.

Regulated health professions in B.C. have the privilege and responsibility to govern themselves in the public interest. Enhanced quality and accountability mechanisms are needed in response to emerging technology, new research, changing practice standards and higher public expectations for accountability of individual health professionals.

MOHS — Performance Measure 5: Improved governance and accountability framework developed for the health professions.

Target 2004/05: "Reserved Actions" model implemented and updating scope of practice regulations underway.

Rationale: Effective self-regulation of health professionals in the future will not be feasible without comprehensive, modernized legislation. There are currently 10 statutes regulating 24 professions, based on an exclusive scope of practice model. The province is working toward an umbrella regulatory framework under a single statute using a shared scope of practice/reserved actions model. This new framework will provide consistency and fairness in requirements relating to governance structures and transparency, registration processes, and inquiry and discipline matters. It will also facilitate development of common jurisprudence, counter perceptions of "hierarchy" among professions, enhance interdisciplinary practice, increase accessibility and consumer choice, and improve cost effectiveness.

Progress: Proposed new regulations were released for optometrists in April 2004 and registered nurses (including nurse practitioners) in November 2004. Both regulations included specified reserved actions based on recommendations of the Health Professions Council. The new regulations for registered nurses (including nurse practitioners) are expected to come into force in 2005.

MOHS Strategy 5: Develop coordinated system-wide approaches for responding to major public health risks and epidemics (e.g., SARS, West Nile, influenza, meningitis and obesity).

The outbreak of SARS in 2003 demonstrated the importance of preparation, coordination and communication among health care partners and stakeholders to minimize the impact of communicable disease. Monitoring population health status and detecting and responding to outbreaks of disease and other health-related issues are key functions of the ministry and its partners.

Progress: The ministry works closely with the BC Centre for Disease Control and public health staff in the health authorities to prevent, monitor, and control the occurrence of communicable diseases in the province. For example, the ministry has prepared for the potential arrival of West Nile virus by expanding surveillance and testing in every health authority for the virus, as well as by establishing a provincial planning committee to coordinate British Columbia's approach to preparing for the virus' arrival. The ministry has also directed additional funding towards immunization programs to prevent influenza and meningitis.

Core Business: Stewardship (continued)

Goal: Improved Health and Wellness for British Columbians (continued)

Goal: High Quality Patient Care (continued)

Objective 2: Support — Supports are in place to facilitate the achievement of strategic priorities, and barriers to change have been removed.

The ministry supports its service delivery partners (health authorities and health professionals) in achieving the strategic priorities of the health system; it develops provincial plans for the future supply and effective use of health care professionals, equipment, technology and facilities to ensure the health system has the capacity to meet the population's health needs. The ministry also supports health research and the development of best practices for service delivery, and develops legislative, regulatory and policy frameworks to manage the health system and protect public health and safety.

The ministry has undertaken several strategies to support its partners and the health system. The following pages outline each of the strategies and report on the progress to date in meeting the performance expectations in the 2004/05 – 2006/07 Service Plan.

MOHS Strategy 6: Make data accessible, with due attention to quality, security and privacy protection, to support evidence-based planning of patient care and clinical decision-making by partners (e.g., Electronic Health Record; CDM registries; inter-provincial/national data collection standards and registries).

Decisions in the health care system should be based on evidence. The ministry is working with its partners to develop and strengthen data and information systems to build capacity for evidence-based strategic planning and decision-making. One important component of this work is the Electronic Health Record (EHR) system. It is a cornerstone of government's strategy to deliver faster and more effective treatment to patients, and enable better information collection and sharing.

MOHS — Performance Measure 6: Health authorities' ratings of data availability and usefulness in supporting planning and service delivery.

Target 2004/05: Implement survey and determine baseline data

Rationale: Similar to the performance measure on government strategic direction and feedback, the ministry also wants to receive feedback from the health authorities on the usefulness of data supplied by the ministry. This feedback will help improve the way data is used to support decision-making in the health system.

Progress: The ministry is nearing completion of the survey tool with implementation of the survey scheduled for Fall 2005.

MOHS Strategy 7: Provide legislative, regulatory and policy frameworks to ensure policy direction is clear and consistent and that services are delivered appropriately and cost-effectively.

A core function of government is to provide the legislative governance framework for the health system. The ministry regularly assesses the need for new or amended legislation, regulation or policy to ensure the system operates in the public interest.

MOHS — Performance Measure 7: Percentage of regulatory requirements reduced.

Target 2004/05: Further reduction in regulations to meet government regulatory reduction targets

Rationale: In 2001, government committed to reduce the overall regulatory burden in British Columbia by one-third to be consistent with global trends in regulatory reform and management. The ministry has worked to reduce regulatory requirements in the health sector to streamline and update the overall legislative framework and reflect an outcome-based approach. This work has been undertaken while recognizing the need to preserve those regulations that are essential to the protection of public health and safety.

The Ministry of Health Services will contribute to government's intention to maintain a zero per cent increase to the baseline regulatory count through the next three fiscal years. The ministry will continue to identify regulatory reduction and reform opportunities, and focus on improving regulations to ensure they are consistently results-based, cost-effective, flexible and promote competitiveness and innovation.

Progress: Government has achieved its target of reducing the overall regulatory burden in B.C. by one-third.

MOHS Strategy 8:	**Ensure the health care system has the capacity to meet the population's health needs by developing provincial plans for the supply and effective use of health care professionals, facilities, and infrastructure.**

The ministry has made a commitment to include longer-term planning in the management of the health system. This focus provides an opportunity to identify strategies that will effect systemic change in the health system for the long-term. Also, by involving health authorities in developing plans for health facilities and medical equipment, we can ensure capital funding is used in the best manner to meet the population's current and future needs.

MOHS — Performance Measure 8:	Health Human Resource, IT, and Capital plans developed.

Target 2004/05: Health Human Resources plan, IT plans and Capital plan.

Rationale: Health human resource, information technology and capital planning all benefit from a province-wide perspective. Accordingly, the ministry is involved with health authorities and other partners (e.g., Ministry of Advanced Education, universities and colleges, Government of Canada, professional groups) to ensure planning in these fundamental areas is integrated and coordinated to maximize benefits from investments and strategies.

Progress

a) Health human resource planning: Government has made great progress in planning for the future supply of health professionals in British Columbia. In 2004/05, over 450 new educational spaces were created for nurses, allied health professionals and midwives. That brought the total number of new educational spaces created up to almost 2,800 since 2001/02. In addition, the province has also increased physician education spaces (from 120 first-year students in 2000 to 224 first-year students in 2005) through the expansion of the UBC Medical School, including the development of new campuses in Prince George and Victoria.

Health human resource planning remains a priority for the ministry and the government. As part of the 2004 First Ministers' Ten-Year Plan to Strengthen Health Care, British Columbia is participating in developing and publishing a health human resource action plan by December 2005.

b) Information technology planning: The ministry develops and publishes an annual Information Resource Management Plan. A summary of the ministry's plan for 2005/06 is available at: http://www.healthservices.gov.bc.ca/cpa/publications/index.html *.

c) Capital planning: The ministry works with health authorities to develop and implement three-year capital plans that address capital needs across the spectrum of provincial health services. In 2005/06, the ministry will be working with health authorities on developing longer-term (10 year) capital plans to meet the future infrastructure requirements of the health system.

Information on capital investments in B.C.'s health system can be found in Appendix B.

MOHS Strategy 9: Support health research and create opportunities for health partners to share knowledge and best practices to facilitate continuous improvement in service delivery.

Research, evaluation and information management are essential to enhancing our capacity to share knowledge and best practices and continually improve B.C.'s health system. The ministry does this through supporting the work of key health research organizations in B.C.

B.C.'s provincially mandated health research organization, the Michael Smith Foundation for Health Research (MSFHR), works to achieve ministry goals, serving as a catalyst to build B.C.'s capacity for excellence in clinical, biomedical, health services and population health research. Its mandate includes advancing provincial, inter-provincial and national initiatives that expand health research support and opportunities; working with health research stakeholders to identify, prioritize and respond to provincial priorities; and delivering innovative programs to address the key building blocks of a vibrant, sustainable research effort.

In late 2003/04, the ministry provided MSFHR with $24.27 million to fund programs in British Columbia that continue to develop, attract and retain outstanding health scientists and researchers; and to support the newly established Health Services and Policy Research Support Network's research activities in priority areas that support health care re-engineering and innovation. In addition, in February 2005, the province announced a commitment to renew MSFHR's mandate, pledging $100 million in continuing support by 2007. $30 million of that commitment was provided to MSFHR in March 2005.

The ministry also supports and commissions directed research through contracts with universities and organizations to meet its own health research priorities in key service delivery areas:

- UBC's Centre for Health Services Policy Research: $1.45 million in funding for 2004/05
- UNBC's Rural and Remote Health Research Institute: $273,000 in funding for 2004/05
- UBC's Mental Health Evaluation and Community Consultation Unit: $1.13 million for 2004/05
- B.C. Injury Research and Prevention Unit: $538,000 in funding for 2004/05.

* *Refer to note on page 3.*

In 2004/05, the ministry provided $12.5 million in one-time funding to support the research activities of the following agencies:

- The Brain Research Centre ($1 million)
- The Prostate Centre at Vancouver General Hospital ($1 million)
- Women's Health Research Institute ($2 million)
- Genome B.C. ($5 million)
- Tri-ministry funding to support B.C.'s portion of a larger CIHR Autism Research Project (ministry contribution totaling $500,000)
- Establishment of a Patient Safety Research Chair at UBC ($3 million).

Core Business: Stewardship (continued)

Goal: Improved Health and Wellness for British Columbians (continued)

Goal: High Quality Patient Care (continued)

Goal: Sustainable, Affordable Health Care System

Objective 3: Monitoring, Evaluation and Course Correction — Delivered services meet public needs and are sustainable.

The ministry monitors and evaluates the delivery of services and the health of B.C.'s population to ensure services meet patients' and the public's needs. As part of a commitment to continuous improvement and evidence-based decision-making, the ministry uses its evaluations of health system performance to inform strategic intervention and facilitate course correction if required.

The section contains key strategies the ministry has undertaken to enhance its monitoring and evaluation functions.

MOHS Strategy 10: Develop an effective monitoring and evaluation framework for services provided by health authorities and other system partners (e.g., health professions).

Monitoring and evaluating the level, quality and impact of services delivered to the public by the ministry's partners is critical to ensuring the public receives value for health expenditures. The ministry must ensure patients are able to access appropriate services that meet their needs, while at the same time ensuring limited health funding is spent efficiently. To that end, the ministry has developed an accountability and performance-monitoring framework for services delivered by health authorities. In 2002, for the first time in Canada, the ministry established performance agreements with each health authority that outlined expectations and performance targets. These performance agreements continue to be renewed annually, with modifications and improvements being incorporated as experience is gained.

Performance Measure 9: Health authority performance agreements signed.

Target 2004/05: Performance agreements signed by all health authorities by May 31, 2004.

Rationale: Performance agreements set out direction and expectations for each health authority for health system governance and health service delivery. They contain specific targets for system performance improvements in key areas, such as emergency services, surgical services, mental health and addiction services, home and community care, public/population health, Aboriginal health, and support and administrative services. Each of these targeted improvements support achievement of the ministry's service plan goals and objectives.

Progress: All regional health authorities signed their performance agreements by August last year, with the Provincial Health Services Authority signing in November.

MOHS Strategy 11: Monitor financial status to ensure overall health system costs stay within budget.

B.C.'s health services budget has continued to grow — the ministry's budget for 2004/05 was over $10.7 billion and health spending consumed approximately 43 per cent of all government spending. It is important this funding is used wisely to provide the best care and achieve the best outcomes for patients — and that all parts of the system manage within their allocated budgets. The ministry monitors financial status throughout the year so any problems can be identified and addressed, and ensures overall costs remain within its budget.

MOHS — Performance Measure 10: Overall health system financial status (actual expenses compared to budgeted expenses at year end).

Target 2004/05: Expenses do not exceed budget.

Progress: Health expenses did not exceed budgeted expenses for 2004/05. For details, please see Appendix B — Report on Resources.

MOHS Strategy 12: Monitor and report publicly on the health of the British Columbia population.

Monitoring the health status of the population is essential for assessing the effectiveness of health programs and services. Health status is influenced by a number of factors including the social, economic and physical environment, personal health practices, individual capacity and coping skills, human biology, early childhood development, health services, gender and culture. While many of these factors lie beyond the jurisdiction of the health system, surveillance and assessment of population health assists government and the ministry address issues or trends and develop healthy public policy.

MOHS — Performance Measure 11: Report annually on population health status or a significant health issue.

Target 2004/05: Annual Report produced (topic: air quality).

Rationale: The Provincial Health Officer (PHO) reports publicly each year on the health of the population. The PHO is the senior medical health officer for British Columbia and provides independent advice to the Minister of Health Services and the ministry on public health issues and population health.

Progress: The Provincial Health Officer released the annual report "Every Breath You Take... Air Quality in British Columbia, A Public Health Perspective". The report can be found at: http://www.healthservices.gov.bc.ca/pho/pdf/phoannual2003.pdf *.

Core Business: Corporate Management

In order to provide effective leadership to the health system and meet its stewardship obligations, the ministry must manage its own operations efficiently and effectively. Corporate management includes managing ministry budgets, human resources and information needs. The ministry included two objectives for Corporate Management in its 2004/05 service plan.

Goal: A Sustainable, Affordable Health Care System (continued)

Objective 1: Appropriate organizational capacity to manage the health system and efficiently deliver necessary services.

The ministry has significantly changed its role in the health system. In the past, the ministry was predominantly involved in the direct delivery of health services. Now, the ministry is primarily focused on being a steward of the health system. This change in focus has required the ministry to develop new areas of expertise, such as planning, monitoring and evaluating services delivered by other agencies. This objective, and the strategy and performance measure below, helps ensure the right mix of skills are available throughout the organization to successfully manage the health system.

MOHS Strategy 13: Implement Human Resource Management Plan.

In order to achieve the strategic objectives in the service plan, additional effort must be focused on developing and supporting the ministry's employees, and continuing to build an enriching, rewarding and flexible organization. To do so, the ministry has been implementing a human resource strategy that supports the Corporate Human Resource Plan for the Public Service of British Columbia. A summary of the ministry's strategy can be found on its website: http://www.healthservices.gov.bc.ca/cpa/publications/index.html *.

* *Refer to note on page 3.*

MOHS — Performance Measure 12:	Percentage of employees who indicated comprehension of vision, mission, and goals of the organization and their role in assisting to achieve these goals. (Annual Employee Survey).

Target 2004/05: 65 per cent.

Rationale: In 2003 and 2004 the ministry conducted annual surveys of organizational health. The purpose of the surveys was to measure satisfaction levels and to identify issues of importance to staff in six aspects of organizational health: communication, leadership, personal and professional development, quality of life, recognition and involvement.

Progress: The ministry will either participate in a cross-government survey by the BC Public Service Agency or conduct its own survey in the Fall of 2005.

In 2004/05, the ministry continued its efforts to align employee planning with the overall strategic direction of the ministry. All employees have developed an Employee Performance and Development Plan, which details individual work and development goals that support the ministry's strategic direction. Implementation of employee plans that directly link with organizational strategic plans is expected to focus work effort in key areas of importance and improve employee understanding of the broader implications and impact of their work on the ministry's attainment of its goals.

Core Business: Corporate Management (continued)

Goal: A Sustainable, Affordable Health Care System (continued)

Objective 2: Sound management practices in place.

The first objective under Corporate Management was to have the appropriate personnel with the required abilities in the ministry. The second objective is to have the business and operational practices in place to maximize the human resources and ensure the production of quality work. The ministry is committed to adopting sound management practices and operating in an innovative, enterprising, results-oriented and accountable manner.

MOHS Strategy 14: Embed sound management practices within the ministry.

Over the past four years the ministry has undergone a shift in its management approach. Structured planning and performance monitoring has become the new standard of operation throughout the organization. In practical terms, this means that strategic priorities and operational plans and activities set at the division, department and individual level are aligned with and contribute to the overall priorities of the ministry and government. The adoption of integrated planning and performance monitoring helps the ministry ensure resources are focused on identified priorities.

MOHS — Performance Measure 13: Percentage of divisions with integrated service (business) and HR plans.

Target 2004/05: 80 per cent of divisions have integrated plans.

Rationale: In adopting integrated planning, the ministry has focused initial efforts on the development of service or business plans for each division of the ministry. These plans present the activities each division is undertaking to achieve the ministry's service plan goals, objectives and strategies. (The ministry has nine divisions. A division is an organizational unit headed by an Assistant Deputy Minister.)

Progress: All divisions have prepared plans that align their activities with the goals, objectives and strategies detailed in the ministry's 2005/06 – 2007/08 service plan.

MOHS — Performance Measure 14: Percentage of divisions with risk management plans.

Target 2004/05: 30 per cent of divisions have risk management plans.

Rationale: Government has made a commitment to structured and evidence-based planning and decision-making. Conducting risk assessments of plans, programs or policies can be a useful tool in ensuring sound decisions are made.

Progress: The ministry has made good progress in implementing risk management processes where they will have significant benefit in informing planning and operational decisions. The ministry's corporate audit committee uses risk assessment to assist in developing an annual audit plan. In addition, the ministry has focused on integrating risk methodology into the ministry's project management approaches where it has an immediate impact in assisting project completion. To date, risk assessment and management methodology has been used to assist in complex projects with multiple stakeholders, such as the Small Water Systems Review Project (part of the Drinking Water Action Plan) and the Meat Inspection Regulation consultation project.

Appendix B: Report on Resources

	Estimated[1]	Other Authorizations[2]	Total Estimated	Actual	Variance (Actual minus Total Estimated)[3]	% of Budget
Operating Expenses ($000)						
Services Delivered by Partners						
Regional Health Sector Funding	6,495,945	147,986	6,643,931	6,665,103	21,172	
Medical Services Plan	2,568,158	0	2,568,158	2,545,815	(22,343)	
Pharmacare	830,355	0	830,355	792,832	(37,523)	
Debt Service Costs	173,500	0	173,500	148,299	(25,201)	
Amortization of Prepaid Capital	136,677	0	136,677	137,285	608	
Sub-Total	**10,204,635**	**147,986**	**10,352,621**	**10,289,334**	**(63,287)**	
Services Delivered by Ministry						
Emergency Health Services	220,602	0	220,602	231,291	10,689	
Health Benefits Operations	18,328	0	18,328	29,775	11,447	
Sub-Total	**238,930**	**0**	**238,930**	**261,066**	**22,136**	
Executive and Support Services						
Minister's Office	778	0	778	729	(49)	
Stewardship and Corporate Management	107,167	0	107,167	108,497	1,330	
Sub-Total	**107,945**	**0**	**107,945**	**109,226**	**1,281**	
Recoveries — Health Special Account	(147,250)	0	(147,250)	(147,250)	0	
Total Vote 25 — Ministry of Health Services	10,404,260	147,986	10,552,246	10,512,376	(39,870)	
Health Special Account	147,250	0	147,250	147,250	0	
Vote 26 — Vital Statistics	6,935	0	6,935	6,755	(180)	
Sub-total — Operating Expenses	**10,558,445**	**147,986**	**10,706,431**	**10,666,381**	**(40,050)**	**0.4%**
Adjustment of Prior Year Accruals[4]				(59,943)	(59,943)	
Total — Ministry of Health Services	**10,558,445**	**147,986**	**10,706,431**	**10,606,438**	**(99,993)**	**1.0%**

[1] Estimated amounts correspond to the *Estimates* presented to the Legislature on February 17, 2004.

[2] Other Authorizations is made up of Supplementary Estimates passed in May 2004 for the following additional federal funding:

• Canada Health & Social Transfer Supplement	130.961m
• Public Health & Immunization Trust	17.025m
	$147.986m

[3] Variance display convention has been changed this year to be consistent with the change introduced in public accounts. Variance is in all cases "Actual" minus "Total Estimates". Where the Actual is greater the Variance is displayed without brackets.

[4] Adjustment of prior year accruals. Amounts reflect adjustment of prior year's expense accruals which were credited to revenue and therefore not available for the ministry to spend. In 2004/05 the adjustment was credited to ministry expense and again was not available for spending.

Operating Expense Variance Explanations

The Ministry of Health Services 2004/05 budget was $10.71 billion (includes *Estimates* and Supplementary Estimates). The actual spending for the fiscal year ended March 31, 2005 totaled $10.67 billion, resulting in an operating surplus of $40 million, which represents 0.4 per cent of the budget. In addition, an accounting adjustment to reverse prior year accruals of $60 million was credited to the ministry budget as a year-end adjustment. Accrual reversals are a normal part of accounting practices, however, in prior years these adjustments were applied to the Consolidated Revenue Fund and were unavailable to the ministry for spending. A change in accounting practice in 2004/05 resulted in these adjustments being credited to the ministry budget; however, once again they were not available to the ministry to spend. This adjustment results in a total ministry surplus of $100 million.

Regional Health Sector Funding: The deficit was primarily due to increased funding to the Michael Smith Foundation for Health Research.

Medical Services Plan: The surplus in 2004/05 was primarily due to lower spending for Alternative Payments and physician benefits payments to the Canadian Medical Protective Association.

PharmaCare: The surplus in PharmaCare is primarily related to lower than anticipated Fair PharmaCare price and utilization increases.

Health Benefits Operations: Health Benefit Operations deficit is primarily due to additional costs to maintain current service levels and one time transition costs to implement the ASD initiative.

Emergency Health Services: Emergency Health Services was overspent due to wage increases of 1.4 per cent and annualized costs of shift adjustments. An increase in fuel costs for ground and air service delivery and increases in contract rates for air carriers also contributed to the overage.

Debt Service Costs: Debt servicing surplus at year-end is due to lower debt balances, lower interest rates and less capital spending than originally planned.

	Estimated[1]	Other Authorizations	Total Estimated	Actual	Variance (Actual minus Total Estimated)[2]
Full-time Equivalents (Direct FTEs)					
Health Services — Ministry Operations					
Emergency Health Services	1,895		1,895	1,884	(11)
Stewardship and Corporate Management	677		677	576	(101)
Health Benefits Operations	115		115	243	128
Minister's Office	9		9	8	(1)
Sub-Total — Ministry Operations	**2,696**	**0**	**2,696**	**2,711**	**15**
Vital Statistics	89		89	77	(12)
Total Ministry of Health Services	**2,785**	**0**	**2,785**	**2,788**	**3**

[1] Estimated amounts correspond to the *Estimates* presented to the Legislature on February 17, 2004.

[2] Variance display convention has been changed this year to be consistent with the change introduced in public accounts. Variance is in all cases "Actual" minus "Total Estimates". Where the Actual is greater the Variance is displayed without brackets.

The FTE budget was 2,785 in 2004/05. Actual FTE utilization was 2,788 resulting in an over-utilization of three FTE's. Delays in implementing the ASD initiative in HBO resulted in an over-burn of approximately 128 FTE's, offset by recruitment lag elsewhere in the ministry.

	Estimated[1]	Other Authorizations	Total Estimated	Actual	Variance (Actual minus Total Estimated)[2]
Ministry Capital Expenditures (Consolidated Revenue Fund) ($000's)					
Health Services — Ministry Operations					
Stewardship and Corporate Management	8,050		8,050	7,658	(392)
Emergency Health Services	11,006		11,006	9,086	(1,920)
Sub-Total — Ministry Operations	**19,056**	**0**	**19,056**	**16,744**	**(2,312)**
Vital Statistics	550		550	253	(297)
Total Ministry of Health Services	**19,606**	**0**	**19,606**	**16,997**	**(2,609)**

[1] Estimated amounts correspond to the *Estimates* presented to the Legislature on February 17, 2004.

[2] Variance display convention has been changed this year to be consistent with the change introduced in public accounts. Variance is in all cases "Actual" minus "Total Estimates". Where the Actual is greater the Variance is displayed without brackets.

The Consolidated Revenue Fund Ministry Capital budget was $19.61M in 2004/05. The surplus was mainly due to under-spending on information systems in Emergency Health Services.

	Estimated[1]	Other Authorizations	Total Estimated	Actual	Variance (Actual minus Total Estimated)[2]
Consolidated Capital Plan ($000's)					
Prepaid Capital Advances	379,700	0	379,700	291,209	(88,491)

[1] Estimated amounts correspond to the *Estimates* presented to the Legislature on February 17, 2004.

[2] Variance display convention has been changed this year to be consistent with the change introduced in public accounts. Variance is in all cases "Actual" minus "Total Estimates". Where the Actual is greater the Variance is displayed without brackets.

The budget for prepaid capital advances was under spent by $88.5 million in 2004/05, due to a $15.25 million reduction in the value of the land transfer from the Province to the Provincial Health Services Authority for the Children's and Women's Health Centre, reductions of $9.0 million with the Vancouver General Hospital Redevelopment Project, and longer than expected project planning processes resulting in delayed project starts and completions.

	Estimated[1]	Other Authorizations	Total Estimated	Actual	Variance (Actual minus Total Estimated)[2]
Financing Transactions (000's)					
Health Innovative Incentive Program	2,034		2,034	769	(1,265)

[1] Estimated amounts correspond to the *Estimates* presented to the Legislature on February 17, 2004.

[2] Variance display convention has been changed this year to be consistent with the change introduced in public accounts. Variance is in all cases "Actual" minus "Total Estimates". Where the Actual is greater the Variance is displayed without brackets.

Financing transaction recovery totaling $0.769M was received in 2004/05 from the Vancouver Island Health Authority as the second, in a series of three repayments for reimbursement of funds provided to them in prior years for the Picture Archiving and Communication (PAC) System.

Health Authorities' Budget

As required under the *Budget Transparency and Accountability Act*, British Columbia's six health authorities are included in the government reporting entity. The health authorities have been primary service delivery organizations for the public health sector for several years and many of the performance measures and targets included in the ministry's service plan are related to services delivered by the health authorities. The majority of the health authorities' revenues and a substantial portion of the funding for capital acquisitions are provided by the province in the form of grants from ministry budgets.

Health Authorities	2004/05 Budget	2004/05 Actual	Variance (Actual minus Total Estimated)[1]
2004/05 Combined Income Statement ($ — millions)			
Total Revenue[2]	8,166	8,580	414
Total Expense[3]	8,166	8,510	344
Operating Results	0	70	70
Gain (Loss) on sale of Capital Assets	0	(4)	(4)
Net Results	**0**	**66**	**66**

This combined income statement is based on audited financial statements from six health authorities and 10 hospital societies. Numbers do not include the eliminating entries required to consolidate these agencies with the government reporting entity.

[1] Variance display convention has been changed this year to be consistent with the change introduced in public accounts. Variance is in all cases "Actual" minus "Total Estimates". Where the Actual is greater the Variance is displayed without brackets.

[2] Revenue: Includes provincial revenue from the Ministry of Health Services, plus revenues from the federal government, co-payments (which are client contributions for accommodation in care facilities) and fees and licences.

[3] Expenses: Provides for a range of health care services, including acute care and tertiary services, residential care, mental health services, home care, home support, and public health programs.

Capital Investment

Capital investment in the health sector funds a wide range of assets from facilities (such as hospitals and residential care facilities) to equipment (from MRI and CT scanners through to hospital beds) and, increasingly, information technology tools and systems that support patient care and health system management (such as the Electronic Health Record and Telehealth technologies). This infrastructure is the foundation that allows health professionals to provide quality health care and services to British Columbians.

The province has initiated major changes over the past four years that encourage more strategic investment of capital and more innovative approaches to meeting infrastructure needs. The ministry has introduced a longer planning cycle for capital projects and has gathered better data on current capital assets to assist improved decision-making. The ministry is now working to extend the planning horizon to ten years, particularly for major projects such as hospitals with life cycles that typically encompass several decades. A longer planning horizon better reflects the long-term nature of capital planning and the life-cycle approach to the management of capital assets that considers both capital and operating costs in the decision-making process.

In 2004/05, the ministry made significant capital investments to improve B.C.'s health system. The following pages of this appendix provide an overview of those investments.

Three-Year Capital Spending Plan

The ministry's three-year capital spending plan encompasses maintenance, renovation, replacement and expansion of health infrastructure that is consistent with regional priorities. For 2004/05, health authorities used ministry funding (in some cases, in collaboration with

other sources such as the federal government, Regional Hospital Districts, foundations, auxiliaries or the private sector) for purposes such as purchasing equipment, building new and replacement facilities and converting existing facilities to uses more consistent with current and future needs. For example:

Fraser Health

- Peace Arch Hospital in White Rock; $1.9 million renovation to the Berkeley Pavilion to support the relocation and consolidation of various community services (Home Health Care, Mental Health Centre, Public Health, Screening Mammography and the Wellness Centre) to the hospital site.
- Royal Columbian Hospital in New Westminster; a new $5 million angiography interventional unit featuring leading-edge imaging equipment that will provide safer, less invasive care for patients.

Vancouver Coastal Health

- Powell River General Hospital's $2.5 million renovations for a Primary Health Care Access Centre to co-locate various community programs to the hospital site.
- Vancouver General Hospital; $2.2 million conversion provided additional Intensive Care Unit beds.

Interior Health

- Emergency and medical imaging departments at the Royal Inland Hospital, the first phase of the $27.5 million second floor redevelopment.
- Construction began on the 44-bed tertiary mental health facility at the Royal Inland Hospital ($16.4 million).
- Renovations to upgrade the maternity units in Kelowna, Vernon and Nelson ($2.1 million).

Northern Health

- Construction began on the replacement of Omineca Lodge in Vanderhoof, scheduled for completion in the summer of 2005 ($7.5 million).
- Renovation to incorporate community health services into Chetwynd General Hospital ($1.14 million).
- Seven Sisters 20 bed Adult Residential Mental Health Facility in Terrace ($2.5 million).

Vancouver Island Health

- Construction is underway for Nanaimo Regional General Hospital's $35.8 million acute care redevelopment, which includes a $23 million surgical expansion to be completed in 2005. The new $12 million perinatal services component is planned for completion in Spring 2006.
- Lady Minto Hospital in Ganges; $3 million surgical expansion and creation of a palliative care suite.

Provincial Health Services Authority

- B.C. Children's and Women's Health Centre's $2.7 million Neonatal Nursery Redesign project consolidated nursery functions and enlarged the Special Care Nursery area.
- B.C. Children's and Women's Health Centre's $4.4 million Nursing Unit renovations will combine two nursing units into a new 32-bed unit, including nine isolation rooms. The project is under construction and scheduled for completion in the summer of 2005.

Across the Province

Medical School Expansion:

In 2004/05, the Province committed $27.6 million for expansion and upgrading of academic space in teaching hospitals around B.C. to support the increasing number of undergraduate and postgraduate medical students. The University of British Columbia's Faculty of Medicine is working with the University of Northern B.C., the University of Victoria and the health authorities to provide medical student education province-wide.

Funding will be invested between 2004/05 and 2008/09 as follows:

- Fraser Health Authority $4.1 million.
- Interior Health Authority $.7 million.
- Northern Health Authority $6.7 million.
- Vancouver Island Health Authority $6.2 million.
- Vancouver Coastal Health Authority/Provincial Health Services Authority $10 million.

First Ministers' Accord on Health Care Renewal — Diagnostic and Medical Equipment Fund

The 2003 First Ministers' Accord on Health Care Renewal established a $1.5 billion national diagnostic and medical equipment fund. Of that total, $200.1 million was allocated to B.C. for the three-year period ending in 2005/06.

The following outlines cumulative spending to March 31, 2005 by category.

- Comfort/Safety for Patients and Staff $9.3 million.
- Diagnostic and Therapeutic Equipment $54.4 million.
- Medical Surgical Equipment $20 million.

In 2004/05, the funding contributed to the purchase of a wide variety of equipment such as:

Fraser Health

- Replacement Catheter Laboratory at Royal Columbian Hospital ($2 million).
- Two new computed radiography systems at Langley Memorial Hospital ($.5 million).

Interior Health

- Picture Archiving Communication Systems in various sites throughout the Interior Health region costing over $12 million.

Northern Health

- Chemistry Analyzers for Burns Lake and Terrace ($.2 million).
- Interventional unit for Prince George Regional Hospital ($.7 million).
- Dawson Creek Hospital — Digital Radiographic/Fluoroscopic Unit ($.7 million).

Vancouver Coastal Health

- Upgraded nuclear medicine camera at Vancouver General Hospital ($1 million).
- 64 Slice CT Scanner at Lion's Gate Hospital ($1.8 million).

Vancouver Island Health

- Two Digital Fluoroscopy units for Nanaimo Regional General Hospital ($2.2 million).
- Radiographic/Fluoroscopic unit for St. Joseph's General Hospital in Comox ($.56 million).
- Campbell River District Hospital — General Ultrasound unit ($.3 million).

Provincial Health Services Authority

- MRI at Children's and Women's Health Centre ($4.1 million).
- X-ray and Radiography Imaging System at BC Cancer Agency in Vancouver ($.7 million).

The September 2004 First Ministers' Agreement committed an additional $66 million in Medical Equipment funding for British Columbia. Health authorities have already begun planning for the use of this funding to best meet the needs of British Columbians in coming years.

In December 2004, the province announced the investment of $35 million in leading edge medical technology to improve access to better treatment and care for British Columbians. These purchases were made possible through funds from the province and the 2003 First Ministers' Diagnostic and Medical Equipment fund. Highlights of the new equipment include:

- the first publicly funded PET unit for the province, to be located at Vancouver Cancer Centre;
- three new 64 slice CT scanners at Royal Columbian Hospital, Royal Jubilee Hospital and Vancouver General Hospital;
- mobile MRI scanner for the Kootenays and south Okanagan, and a new 32 slice CT scanner at Kelowna General Hospital (with support from local foundations);
- MRI scanner upgrade at UBC Hospital;
- advanced radiology and pharmaceutical systems for the Northern Health Authority;
- laboratory centre of excellence for genomics in Vancouver; and a
- radiopharmaceutical lab and cyclotron at Vancouver Cancer Centre.

Most of the new equipment will be in operation in 2005, and the remainder in 2006.

Major Capital Projects

In compliance with the provincial *Budget Transparency and Accountability Act*, major capital project plans are made public. A major capital project is defined as any capital commitment or anticipated commitment that exceeds $50 million.

Projects may be publicly funded or structured as public private partnerships, designed to leverage private sector innovation and capital, where such an approach ensures better value for health care dollars.

In 2004/05, commitments were made to:

Vancouver General Hospital Redevelopment (VGH) — Vancouver Coastal Health Authority

Objective: The hospital redevelopment is to consolidate patient services and clinical expertise to assist in meeting patient care needs over the next 20 years or more.

Cost: Total capital cost is $156 million.

Benefits: Anticipated benefits are new patient areas and consolidation of hospital services within the Centennial Pavilion and the Jim Pattison Pavilion to create a modern and efficient hospital environment for enhanced patient care and accessibility.

Risks: The project could potentially be affected by delays, changes in economic and market conditions (including potential for labour and material cost escalation and shortages), and technology and/or building code changes.

As of the end of March 2005, approximately $93 million had been expended on the project, which is due for completion in early 2007.

Academic Ambulatory Care Centre (AACC) — Vancouver Coastal Health Authority

Objective: The AACC is a state-of-the-art, 11-storey, 365,000-square-foot facility planned for the Vancouver General Hospital (VGH) site. The project will be completed through an agreement with Access Health Vancouver (AHV), a team of companies selected through an open competitive process.

Benefits: The AACC will provide single-site access to a range of outpatient (ambulatory) services along with undergraduate and post-graduate medical education facilities, teaching physician/specialist practice offices, and related commercial/retail activities. The facility is expected to support several hundred medical students, approximately 580 medical and allied professionals, and an estimated 600,000 patient visits annually.

Cost: The capital cost for the project is estimated at $95 million.

Risks: Under the terms of the partnership agreement finalized in September 2004, each party has agreed to assume the risks it can manage best at the least cost. During the construction phase, the health authority assumes only those risks related to matters under its control, such as decisions on space allocation. To mitigate these risks, VCHA is working

to ensure its planning processes meet specific milestones in the agreed-upon construction schedule. Project construction commenced in October 2004 and is scheduled for completion in 2006.

For more information on the Academic Ambulatory Care Centre project, please see the ministry's website at http://www/healthservices.gov.bc.ca/cpa/publications/index.html *.

Abbotsford Regional Hospital and Cancer Centre — Fraser Health Authority and Provincial Health Services Authority

Objective: The Abbotsford Regional Hospital and Cancer Centre (AHCC) will be a new 300-bed facility that replaces the current 202-bed Matsqui-Sumas-Abbotsford (MSA) hospital, which is aging, physically obsolete, and not suitable for expansion.

Benefits: The new hospital and cancer centre will provide enhanced programs and services to meet the needs of Fraser Valley residents, and will also help to recruit and retain health professionals. AHCC includes integration of a new cancer treatment centre that will be part of the provincial network operated by the BC Cancer Agency.

Cost: The capital cost of the project is estimated to be $355 million. The Fraser Valley Regional Hospital District is contributing $71.3 million towards the project.

Risks: This is the province's first public private partnership project for a major acute health care facility. To mitigate risks, the AHCC team is building on the experience, documentation and advice of other jurisdictions that have completed similar projects. Risks have been allocated between the parties as part of the public private partnership contractual agreement. For example, the private sector partner will manage the design and construction risk.

Construction, which commenced in December 2004, is expected to end in Spring 2008, with the facility opening for patients in Summer 2008.

For more information on the Abbotsford Regional Hospital and Cancer Centre project, please see the ministry's website at: http://healthservices.gov.bc.ca/cpa/publications/index.html *. To see Partnerships British Columbia's value for money report on the project, go to: http://www.healthservices.gov.bc.ca/cpa/publications/PBCAbbotsford.pdf *.

* *Refer to note on page 3.*

Appendix C: Core Business Areas

The core business areas of the ministry are organized to reflect the different roles in the health system. Accordingly, the ministry has three broad core business areas: *Services Delivered by Partners, Services Delivered by Ministry,* and *Stewardship and Corporate Management*. This appendix provides details of the key responsibilities and functions of each core business area.

Core Business: Services Delivered by Partners

B.C.'s health authorities, agencies and direct care providers are the ministry's key partners who deliver the vast majority of health services to the public. These services span beginning to end-of-life care, health promotion to disease prevention, and primary to acute care. Accordingly, this core business accounts for the vast majority of health expenditures, and is the primary focus of the system redesign efforts detailed in the ministry's service plan.

Key areas under this core business include:

Regional Health Sector

2004/05: $6.684 billion (62% per cent of total ministry budget)
72,000 Health Authority FTEs (estimated)

More than 90 per cent of this funding is provided to six health authorities for provision of most local health services, including preventive services, hospital care, home and community care, and mental health and addiction services. In addition, some funding goes to other health agencies, for related services, including: provision of blood services, out of province hospital services, post-graduate medical education, health care risk management, and some palliative care services.

Medical Services Plan

2004/05: $2.568 billion (24% per cent of total ministry budget)

The Medical Services Plan funds medically necessary services provided by physicians, including diagnostic services. Physician services may be funded in a variety of ways: through fees, contracts (including contracts with health authorities), salaried positions or sessions. Funding also provides supplementary benefits for low-income British Columbians for a range of services, including physical therapy, naturopathy and chiropractic.

PharmaCare

2004/05: $830 million (eight per cent of total ministry budget)

PharmaCare is B.C.'s prescription drug insurance program and includes several benefit plans. The largest plan is Fair PharmaCare, providing assistance to B.C. families based on their income. Several other plans exist to address health needs of specific populations, including seniors in long term care facilities, severely disabled children who are cared for at home, enzyme treatment for cystic fibrosis suffers, and clients on provincial income assistance.

Capital Financings

2004/05: $310 million

Government provides debt-financed funding to health authorities for specific capital purposes including the capital cost of new buildings, renovations and improvements to health facilities, diagnostic and medical equipment and information technology. Debt service and amortization costs are included.

Core Business: Services Delivered by the Ministry

In 2004/05, this core business encompassed three service areas delivered directly to the public by the ministry: the British Columbia Ambulance Service (BCAS), which is delivered through the Emergency Health Services Commission; the Vital Statistics Agency, which is responsible for documenting important events for B.C. citizens such as births, marriages, and deaths; and Health Benefit Operations which provides administrative services for B.C.'s PharmaCare Program and Medical Services Plan.

Emergency Health Services (BC Ambulance Service)

2004/05: $221 (Two per cent of overall ministry budget)
1,884 FTEs

The BCAS is responsible for providing effective, efficient and equitable emergency health care services for the province. Approximately 1,300 full-time and 1,900 part-time CUPE paramedics and dispatchers provide emergency transport services. BCAS is a provincial service with 190 stations and 460 ambulances across the province, providing more than 460,000 ground calls and 7,000 air evacuations annually.

British Columbia Vital Statistics Agency

2004/05: $6.8 million
89 FTEs

The Vital Statistics Agency is responsible for documenting important events for B.C. citizens such as births, marriages, and deaths. There are two primary outputs of the Agency's vital event registration activities: the production of accurate, timely and relevant health statistics and information, and the issuance of certified documents pertaining to individual vital

events (e.g., birth certificates). The Agency also has a key responsibility to secure and protect personal identity records by taking appropriate measures to prevent identity theft and related frauds as they may relate to British Columbia vital event records and documents.

Health Benefit Operations

2004/05: $18.3 million

Health Benefit Operations provides administrative services for B.C.'s PharmaCare Program and Medical Services Plan. These services do not involve direct health care delivery, but include registering beneficiaries, processing medical and pharmaceutical claims from health professionals, and responding to inquiries from the public. These services were outsourced on April 1, 2005, to Maximus BC to improve service delivery to the public. The new organization operates under the name of Health Insurance BC. In 2005/06, to reflect the change in delivery method, Health Benefit Operations is contained within the ministry's core business of *Services Delivered by Partners.*

Core Business: Stewardship and Corporate Management

As stewards of the system the ministry provides leadership and support to our health system partners, including health authorities, physicians, and other care providers. The ministry sets the overall strategic direction for the health system, provides the appropriate legislative and regulatory frameworks to allow it to function smoothly, and plans for the future supply and use of health professionals, technology and facilities. The ministry also monitors the health of the population and plans for and coordinates responses to major public health risks and emergencies. In addition, the ministry also evaluates health system performance, and takes corrective action where necessary to ensure the population's health needs are being met.

2004/05: $109 million
677 FTEs